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CLICK HERE FOR THE CEO's REPORT DATED OCTOBER 24, 2008

CLICK HERE FOR THE CEO's REPORT DATED DECEMBER 2, 2008

CLICK HERE FOR THE CEO's REPPORT DATED JANUARY 27, 2009

CLICK HERE FOR THE CEO'S REPORT DATED JANUARY 29, 2009

CLICK HERE FOR THE CEO's REPORT DATED DECEMBER 16, 2008
(This Board Letter completes the impact of the State Budget, hiring freeze & programs report)

CLICK HERE FOR THE DORP's REPORT DATED APRIL 8, 2009
(This is a response to the Board's Motion Regarding Mitigation Monitoring Program)

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CLICK HERE FOR THE REGIONAL PLANNING's REPORT DATED APRIL 8, 2009

CLICK HERE FOR THE CEO's REPORT DATED AUGUST 19, 2009

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

October 24, 2008

To: Supervisor Yvonne B. Burke, Chair
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

REPORT ON TRANSFER OF ALCOHOL AND DRUG PROGRAMS ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

On October 7, 2008, your Board approved a motion by Supervisor Michael D. Antonovich instructing the Chief Executive Office to develop recommendations to the Board within 30 days regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH).

Given the significance and potential consequences of the proposed transfer, we are requesting additional time to complete the comprehensive review we have initiated to date. We are researching the background of ADPA's current placement within DPH and the program responsibilities of both ADPA and DMH, studying the merits of comparable organizational models from other counties, and developing information about the feasibility, benefits, and consequences of transferring ADPA to DMH. In addition, both DPH and DMH have client and provider constituencies, including their respective advisory Commissions, which we will involve in our review through the departments' respective stakeholder processes.

In addition to stakeholder input, we will also review studies that were previously conducted regarding this proposed transfer such as the report prepared by the Los Angeles County Civil Grand Jury. As part of an analysis of implementing a health authority for the County's health and hospital system, the 2004-05 Grand Jury recommended that the County consider placing the ADPA function under DMH and creating a Behavioral Health Department. However, on May 30, 2006, the Board approved the creation of DPH, including the continued placement of ADPA within DPH.

Accordingly, we anticipate providing your Board with a written progress report by mid-December 2008 and a final report by March 2009. This time frame will allow us to conduct a meaningful analysis, make sound recommendations and, should a transfer be recommended, prepare for any necessary personnel changes or adjustments to the departments' annual budgets.

If you have any questions or need additional information, please contact me, or your staff may contact Richard Martinez at (213) 974-1758 or rmartinez@ceo.lacounty.gov or David Seidenfeld at (213) 974-1457 or dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
MLM:JS:yb

c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Mental Health
Director and Health Officer, Department of Public Health
Mental Health Commission
Public Health Commission
Commission on Alcoholism
Narcotics and Dangerous Drugs Commission

102408_HMHS_MBS_ADPA Transfer

County of Los Angeles
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WILLIAM T FUJIOKA
Chief Executive Officer

December 2, 2008

TO: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

FROM: William T Fujioka
Chief Executive Officer

STATUS REPORT ON A RAINY DAY FUND

On October 7, 2008, your Board approved a motion directing the Chief Executive Office to report back within 60 days on the feasibility of implementing a "rainy day fund".

Additional time is needed to analyze the issue before we can bring the matter back to your Board. We are now targeting January 27, 2009 to return to your Board with recommendations regarding this item. This will allow us to factor in a number of unresolved budgetary issues such as additional State budget reductions, updated County fiscal forecast, and local revenue projections.

If you have any questions or need additional information, please let me know or your staff may contact Debbie Lizzari at (213) 974-6872.

WTF:SRH:DIL
SK:EC:yjf

c: Executive Officer, Board of Supervisors

Rainy.Day.Fund.bm

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WILLIAM T FUJIOKA
Chief Executive Officer

January 27, 2009

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF RECOMMENDATIONS REGARDING THE USE OF $44.8 MILLION FOR THE PUBLIC PRIVATE PARTNERSHIP (PPP) PROGRAM (ALL DISTRICTS AFFECTED) (3 VOTES)

SUBJECT

This is a joint request, with the Interim Director of Health Services, to approve recommendations developed by the Public Private Partnership (PPP) Allocation Working Group, regarding the use of $44.8 million approved by your Board on October 7, 2008, for the PPP program, included in the attached report. The report also addresses your Board's request that the Chief Executive Officer (CEO) and Interim Director of Health Services determine what methodology can be used to enhance primary care efficiencies and how the specialty clinics will be handled in the augmentation of primary care services.

IT IS RECOMMENDED THAT YOUR BOARD:

Approve recommendations of the PPP Allocation Workgroup regarding the use of $44.8 million for the PPP program and instruct the Interim Director of Health Services to proceed with implementation of the proposals, including: 1) $4.8 million for capital projects/renovations, including equipment, to add or expand PPP clinic capacity in Service Planning Areas (SPAs) 1, 3, 6, 7 and 8; and 2) $40.0 million as follows: a) $1.5 million for the Encounter Summary Sheet project, to include all PPP Strategic Partners in all SPAs; b) $3.0 million for underserved geographic areas in SPAs 2, 4 and 5, for capital infrastructure, including equipment, and to fund new visits at PPP clinic sites; and c) up to $35.5 million over three years to SPAs 1, 3, 6, 7 and 8 for new patients at current or new PPP clinic sites.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On October 7, 2008, your Board approved $44.8 million in one-time funds for the Department of Health Services' (DHS) PPP program and instructed this Office and the Interim Director of Health Services to reconvene the PPP Allocation Workgroup (Workgroup) to develop recommendations to be presented to the Board regarding the use of these funds.

Further, the Board requested the CEO and Interim Director of Health Services to determine what methodologies can be used to enhance primary care efficiencies and how specialty clinic services will be handled with this PPP augmentation.

The Workgroup conducted four public meetings, beginning with the first on November 19, 2008 and the fourth on January 16, 2009. During these meetings, the Workgroup received a considerable amount of input from participants, which the Workgroup considered in developing its recommendations regarding the use of the $44.8 million. The attached report includes the Workgroup recommendations, as well as additional responses and recommendations from CEO and DHS staff regarding the Board's directives.

The Workgroup members acknowledge that underserved areas can be found in all SPAs across Los Angeles County and that existing resources are not sufficient to meet the needs of all uninsured and underinsured County residents. Therefore, the $44.8 million approved by your Board, while one-time in nature, is essential to DHS efforts to support the PPP program.

The Workgroup recommendations offer proposals for the use of these one-time funds to: a) increase capacity in the underserved geographic areas of the County with the least amount of current resources, and b) best position the DHS/PPP program network to benefit from federal funds which could be available for health information technology and to maximize the County's participation in pending health care reforms.

In summary, the Workgroup recommended the following uses of the $44.8 million:

1. Utilize $4.8 million for capital projects/renovations, including equipment, to add/expand clinic capacity in SPAs 1, 3, 6, 7, and 8. Projects should already be designed/initiated with expected completion within two years.

2. Utilize $40.0 million as follows:

    a. $1.5 million for the Encounter Summary Sheet (ESS) project, to include all PPP Strategic Partners in all SPAs.

b. $3.0 million for underserved geographic areas in SPAs 2, 4 and 5, with funds to be used for capital infrastructure, including equipment, and/or to fund new visits at PPP clinic sites.

c. Up to $35.5 million over three years to SPAs 1, 3, 6, 7 and 8 for visits for new patients at current or new PPPs, including visits at sites chosen for the $4.8 million capital/infrastructure projects.

Included in the Workgroup recommendations is a proposal that additional funds from the $35.5 million may be made available for qualifying proposals in SPA 2 underserved geographic areas, as defined in the report, up to an amount that would maintain the SPA 2 proportional allocation of funds as determined by the 2008 Allocation Formula for the PPP program.

The attached report also provides information on DHS initiatives to improve access to, and manage demand for, specialty care services, in response to your Board's request. Among these initiatives is the DHS countywide deployment of the Referral Processing System (RPS), a web-based system that allows DHS and PPP program providers to make electronic referrals to DHS referral centers for specialty care. RPS has improved tracking and disposition of specialty care referrals, provides system wide information on the demand for specialty care, and improves the sharing of information between DHS and PPP providers and the return of the patient to their medical home.

Implementation of Strategic Plan Goals

The recommended actions support goal 7, Health and Mental Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The $44.8 million related to the recommendations consists of $3.5 million in one-time Tobacco Settlement funds already in the DHS 2008-09 Final Budget and $41.3 million in the 2008-09 Provisional Financing Uses (PFU) budget for the DHS PPP program. DHS is not requesting that funds be moved from the PFU budget to the DHS budget at this time. DHS will submit separate requests to your Board for funding as the solicitation process and timeframe is developed. Therefore, there is no additional net County cost impact related to these actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

For purposes of the recommendations in the report, "underserved geographic areas" are federally designated Medically Underserved Areas (MUAs) in which residents have a shortage of health services or Medically Underserved Populations (MUPs), which are groups of persons who face economic, cultural or linguistic barriers to health care. The report includes a map attachment which shows the SPA boundaries and the MUA/Ps within the SPAs. In addition, areas which can clearly demonstrate eligibility for MUA or MUP designation can be considered eligible for this funding.

DHS will convene as needed meetings with the Community Clinics Association of Los Angeles County (CCALAC) leadership and its members to discuss issues related to implementation of these recommendations, including but not limited to actions that can be taken to maximize the use of funds available for proposals in underserved geographic areas where the lack of existing infrastructure is particularly severe. DHS may also use these meetings to discuss issues related to the development of performance measures and future proposals for special projects, as well as other process issues.

Further, DHS will discuss with CCALAC and its members other potential criteria in determining eligibility of "underserved geographic areas" for funds in categories above, including, among others, consideration of Health Resources and Services Administration Health Professional Shortage Area (HPSA) designation.

For planning purposes only, DHS has projected the distribution of the $38.5 million in recommended funding by SPAs based on their relative percentages from the 2008 Allocation Formula. The attached report includes a graph which reflects those planning projections.

In developing the potential distribution, DHS projected funding at a level which maintained SPA 8 at its current relative percentage level based on the 2008 Allocation Formula percentage. DHS then projected the balance of available funds for SPAs 1, 3, 6 and 7 in amounts which would increase their percent of funding to 71.5 percent of their 2008 Allocation Formula percentages. This methodology is similar to one included in the CCALAC written recommendations. For SPAs 2, 4 and 5, DHS allocated the $1.0 million a year based on their relative percentages from the 2008 Allocation Formula.

These planning estimates will change if additional funds are provided to qualifying SPA 2 projects to maintain SPA 2 at the 2008 Allocation Formula percentage. Actual funding percentages will depend on final approval of proposals submitted and qualifying for use of these funds.

CONTRACTING PROCESS

To implement the recommendations above, DHS is working in consultation with County Counsel to develop an expedited solicitation process which DHS is developing, in consultation with County Counsel. DHS will provide the Board, in regular reports beginning in March 2009, with information, including timelines, regarding the solicitation process, copies of the solicitation documents, and progress reports on selection of successful bids and awarding of funds to providers. Approval of funding agreements will be submitted for your Board's approval.

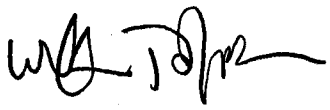
IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended uses of the $44.8 million will increase primary care services to residents in underserved areas of Los Angeles County.

CONCLUSION

The Public-Private Partnership program has been an effective relationship between the providers and Los Angeles County. The services provided by the PPPs are vital to our community and the investment of $44.8 million over the next three years will ensure the program continues and improves.

Respectfully submitted,



WILLIAM T FUJIOKA
Chief Executive Officer

WTF:SRH
SAS:bjs

Attachment

c: County Counsel
Interim Director, Department of Health Services

012709_HMHS_BLT_PPP Recommendations

Public-Private Partnership Program
Report and Recommendations
On Strategic Use of $44.8 Million
January 2009

On October 7, 2008, the Los Angeles County Board of Supervisors (Board) approved $44.8 million in one-time funds for the Department of Health Services' (DHS) Public Private Partnership (PPP) program. These funds consist of $3.5 million in one-time Tobacco Settlement funds already in the DHS 2008-09 Final Budget and $41.3 million in the Provisional Financing Uses budget for the DHS PPP program.

The Board also instructed the Chief Executive Officer (CEO) and the Interim Director of Health Services to reconvene the PPP Allocation Workgroup to develop recommendations to be presented to the Board regarding the use of these funds, including:

- How to most strategically use the $4.8 million in infrastructure dollars in "under-equity" SPAs;
- How to most strategically use the remaining $40.0 million (given the one-time nature of these funds) to address PPP inequity in "under-equity" SPAs over a three-year period, including replicating successful models and leveraging additional outside funding;
- Strategies for improving coordination of care – including the creation of medical homes, especially for frequent users of the emergency room services;
- Strategies on how the use of these funds can be implemented, monitored, and overseen to ensure accountability; and
- Direction that all areas of the County that are federally designated as underserved may be considered, along with "under-equity" SPAs, for funds earmarked for expanded PPP services.

Further, the Board requested the CEO and Interim Director of Health Services to determine what methodologies can be used to enhance primary care efficiencies and how specialty clinic services will be handled with this PPP augmentation.

The following report includes the recommendations of the PPP Allocation Workgroup regarding the use of the $44.8 million, as well as additional responses and recommendations from CEO and DHS staff regarding the Board's directives.

Background on PPP Program and April 2008 Report

Public-Private Partnership Program

The Public-Private Partnership Program is a collaborative effort between DHS and private, community-based providers (PPP providers) to provide quality health care services to the uninsured and underinsured. This program is administered by the DHS-Office of Ambulatory Care and currently includes a budget of over $54 million, which is used to reimburse PPP providers for primary care, dental and specialty services provided to uninsured patients.

Allocation Working Group and 2008 Allocation Methodology

On September 18, 2007, on a motion by Supervisors Molina and Yaroslavsky, the Board established a five-member PPP Program allocation formula working group (Workgroup) to provide recommendations on an equitable, countywide funding allocation methodology that will best meet the health care needs of the uninsured and underinsured residents of Los Angeles County.

As directed in the motion, the five-member Workgroup consisted of the Deputy Chief Executive Officer, Health and Mental Health Services, CEO, who served as Chair of the Workgroup; the DHS Director of Planning and Analysis; the DHS Interim Director of Ambulatory Care; and two representatives of the Community Clinics Association of Los Angeles County (CCALAC), neither of whom are current nor potential future PPP providers.

After a series of public meetings between December 20, 2007 and March 4, 2008, the Workgroup recommended the 2008 Allocation Formula, consisting 100 percent of "unmet need" for the distribution of PPP program funds. The unmet need calculation consisted of a) the number of uninsured (defined as individuals with incomes below 200 percent of the federal poverty level) and b) the utilization rates for uninsured patients based on data from the Los Angeles County Patient Assessment Survey, by Service Planning Areas (SPAs).

In applying the 2008 Allocation Formula, the Workgroup found that clinics in SPAs 2, 4 and 5 had aggregate funding levels above the percentages which would have been allocated to the SPAs using the 2008 Allocation Formula and clinics in SPAs 1, 3, 6, 7 and 8 had aggregate funding levels below the percentages which would have been allocated to those SPAs using the 2008 Allocation Formula. Therefore, due to concern regarding the potential impact on patients receiving services, the Workgroup recommended that the 2008 Allocation Formula not be used to redistribute the current PPP program funding between SPAs. However, in the future, the distribution of new unallocated funds would be based on the 2008 Allocation Formula.

Workgroup Recommendations on $44.8 Million

Background

Over the past several months, as directed by the Board, the Workgroup met in four public meetings to discuss areas under review in developing the recommendations included in this report and to obtain input from the stakeholders, including the CCALAC and its provider members. Participation at the meetings included staff from the Board offices and representatives of Service Employees International Union (SEIU) Local 721.

During these meetings, the Workgroup received a considerable amount of input from participants, including written recommendations from CCALAC and its members (Attachment I) and a summary document (Attachment II) and oral presentation from Bobbie Wunsch, Pacific Health Consulting Group, on recommendations from Key Informant Interviews, which were conducted under a project funded by the California Endowment. Both documents, as well as the stakeholder input from those present at the meetings, were considered by the Workgroup in developing the following recommendations.

Recommendations

It is important to point out, as in the April 2008 Workgroup report, that underserved areas can be found in all SPAs across Los Angeles County and that existing resources are not sufficient to meet the needs of all uninsured and underinsured County residents. Therefore, the Board-approved $44.8 million, while one-time in nature, is essential to the DHS efforts to support the PPP program.

The Workgroup recommendations below offer proposals for the use of these one-time funds to: a) increase capacity in the underserved geographic areas of the County with the least amount of current resources, so they can be prepared to take advantage of other available or new funding opportunities to sustain their operations, and b) best position the DHS/PPP program network to benefit from federal funds which could be available for health information technology and to maximize the County's participation in pending health care reforms.

For purposes of the recommendations below, "underserved geographic areas" are federally designated Medically Underserved Areas (MUAs) in which residents have a shortage of health services or Medically Underserved Populations (MUPs), which are groups of persons who face economic, cultural or linguistic barriers to health care. Attachment III is a map which shows the SPA boundaries and the MUA/Ps within the SPAs.

In addition, areas which can clearly demonstrate eligibility for MUA or MUP designation can be considered eligible for this funding. Further, DHS will discuss with CCALAC and its members potential other criteria in determining eligibility of "underserved geographic areas" for funds in categories below, including, among others, consideration of Health Resources and Services Administration Health Professional Shortage Area designation.

A) Use of $4.8 Million:

Workgroup Recommendation: Utilize funds for capital projects/renovations, including equipment, to add/expand clinic capacity in SPAs 1, 3, 6, 7, and 8. Projects should already be designed/initiated with expected completion within two years.

DHS and CEO propose the following:

a. Projects can be for: 1) (first priority) new sites of new or current PPP providers in underserved geographic areas of these SPAs; 2) (second priority) development of new sites in the SPAs; or 3) (third priority) expansions of existing sites.

   This prioritization was developed in order to first support development of new clinic sites in these SPAs to address the current lack of infrastructure, either in the underserved geographic areas or other close by areas within the SPA. However, on a case by case basis, DHS may determine that the needs of the area would be best and most expeditiously served by expansions of existing sites, as reflected in the CCALAC recommendations for use of the $4.8 million.

b. Projects may include a) new or expanded school-based health clinics that offer services to families and b) PPPs providing services at County directly operated sites.

   This language is intended to clarify that the DHS solicitation process will encourage proposals which seek to leverage other resources in meeting the need for additional infrastructure capacity in these areas.

c. A portion of the $40 million, as described below, should be set aside to fund visits at these new or expanded sites.

   The Workgroup felt it was essential that a portion of these funds be earmarked for new visits to be provided at the clinic sites/expansions funded by the $4.8 million in capital/infrastructure funds.

d. Recipients of funds must identify how County funds will leverage other funding streams and how the clinic will be sustainable after the three years of County funds are depleted.

At the public meetings, there was concern that the $4.8 million may not be enough to make a meaningful investment in infrastructure and a recommendation from some stakeholders that a portion of the $40.0 million should be added to this capital/infrastructure category. However, there were others who felt the amount for this category should be capped at $4.8 million. Ultimately, the Workgroup recommended that the amount be maintained at $4.8 million.

B) Use of $40.0 Million:

The following recommendations were developed to address Board instructions regarding equity issues and increasing primary care visits, as well as strategies for improving coordination of care; how use of funds can be implemented, monitored, and overseen to ensure accountability and encourage best practices; and consideration of all areas that are federally designated as underserved.

The Key Informant Interviews, and input from some stakeholders, included recommendations to use funds to implement new delivery models in order to improve coordination of care. While the Workgroup considered a recommendation to use a portion of the funds for special projects for new models of care, the members ultimately agreed with the general sense from the stakeholders that the best proposals would get funds out as quickly and with as much flexibility as possible.

Recommendations:

1. $1.5 million for Encounter Summary Sheet project, to include all PPP Strategic Partners in all SPAs (improves coordination of care).

   DHS has created an Encounter Summary Sheet (ESS), which is a patient history that is web-accessible and includes administrative and clinical information, such as diagnostics and frequency of visits, procedures performed, past and future appointments and a history of medications dispensed from DHS. Currently, the ESS displays information for services received at DHS facilities within 48 hours of the encounter. For the PPP clinic sites, the data feeding into the ESS is limited to claims data (diagnosis codes and visit date) that may be 45 to 90 days old. The ESS is currently only accessible to clinicians at select DHS facilities.

   Private grant funds have been secured to expand access to up to 16 PPP providers. The proposed $1.5 million would enable the project to expand the type and timeliness of clinical information reflected in the ESS and deliver the ESS to clinicians at all Strategic Partners in the PPP program.

   While the Workgroup acknowledged the importance of expanding the ESS project to all PPP providers, including Traditional Partners, the members believed that these funds, if approved for this project expansion, could be

used by CCALAC and DHS to leverage other private funds for inclusion of all community clinics, as well as funding for participation by private hospital emergency departments.

The Key Informant Interview responses reflected strong support for funding for investment in technology, in part to help ready the PPP provider network for health care reform and to access federal health information technology funds which may become available with the new federal Administration.

While the Workgroup considered whether to recommend the $1.5 million from the $4.8 million capital/infrastructure dollars above, the members ultimately agreed that the $4.8 million level of funding for SPAs 1, 3, 6, 7 and 8 should be maintained. This in part acknowledged the concern that $4.8 million may already be insufficient and, in addition, the fact that the ESS project expansion would benefit providers across all SPAs and not only the ones identified for allocation of the $4.8 million.

This recommendation provides a strategy for improving coordination of care in providing patient data, including frequent users of emergency room services.

2. $3.0 million for underserved geographic areas in SPAs 2, 4 and 5. Funds can be used for capital infrastructure, including equipment, and/or to fund new visits at PPP clinic sites.

While the Workgroup agreed that funding should be identified also to address the needs of underserved geographic areas in SPAs 2, 4 and 5, the difficulty was in identifying data that would assist the Workgroup members in recommending a specific funding amount from the $38.5 million remaining after adjusting for the proposed ESS project funds. Ultimately, the Workgroup's recommendation was based on unanimous agreement for $3.0 million, calculated by recommending $1.0 million per year for three years.

In addition, the Workgroup is recommending that additional funds from the remaining $35.5 million may be made available for qualifying proposals in SPA 2 underserved geographic areas up to an amount that would maintain the SPA 2 proportional allocation of funds as determined by the 2008 Allocation Formula.

Under the current distribution of PPP program funds, PPP clinics in SPA 2 receive almost 17.3 percent of PPP program funds, which is less than one percent above its 2008 Allocation Formula percentage of around 16.8 percent. Receiving only a portion of the $3.0 million would result in

SPA 2 falling below its 2008 Allocation Formula percentage, along with SPAs 1, 3, 6, 7 and 8.

3. Up to $35.5 million over three years to SPAs 1, 3, 6, 7 and 8 for visits for new (unique) patients at current or new PPPs in the following categories:

    i. Visits at sites chosen for the $4.8 million capital/infrastructure projects, including equipment.

    As noted above, the Workgroup felt it was essential that a portion of these funds be earmarked for new visits to be provided at the clinic sites/expansions funded by the $4.8 million in capital/infrastructure funds. This is first priority for these funds.

    ii. The remaining categories are not in priority order and will be subject to evaluation by DHS.

        1. Visits at new PPP sites by current PPP providers in underserved geographic areas in these SPAs and/or visits at sites operated by current PPP providers but not currently funded in their contract.

        2. Additional visits at existing PPP sites in these SPAs.

        3. Additional visits for clinics in SPAs 2, 4, and 5, which provide at least 50 percent of their PPP visits to patients residing in SPAs 1, 3, 6, 7, and 8.

DHS and CEO propose the following:

a. To receive a portion of the $38.5 million for recommendations 2 and 3, performance metrics must be developed, best practices encouraged and clinics must show how new visits can be sustained after 3 years, when County funds are depleted.

    This will allow DHS to monitor the use of these funds in a way that can ensure accountability. DHS will work with its PPP providers to develop similar performance metrics and best practices to incorporate into all PPP provider contracts.

b. Projects may include a) new or expanded school-based health clinics that offer services to families and b) PPPs providing services at DHS directly operated sites.

    As indicated above, this language is intended to clarify that the DHS solicitation process will encourage proposals which seek to leverage other

resources in meeting the need for additional infrastructure capacity in these areas.

c. Recipients of funds must identify how County funds will leverage other funds.

Implementation of Recommendations

To implement the recommendations below, DHS and CEO propose that the $44.8 million be awarded through an expedited solicitation process which DHS is developing, in consultation with County Counsel. DHS will provide the Board, in regular reports beginning in March 2009, with information, including timelines, regarding the solicitation process, copies of the solicitation documents, and progress reports on selection of successful bids and awarding of funds to providers. Approval of funding agreements will be submitted for the Board for approval.

In addition, DHS will convene as needed meetings with the CCALAC leadership and its members to discuss issues related to implementation of these recommendations, including but not limited to actions that can be taken to maximize the use of funds available for proposals in underserved areas where the lack of existing infrastructure is particularly severe. DHS may also use these meetings to discuss issues related to the development of performance measures and future proposals for special projects, as well as other process issues.

For planning purposes only, DHS has projected the distribution of the $38.5 million in recommended funding by SPAs based on their relative percentages from the 2008 Allocation Formula. Attachment IV is a bar chart which reflects those planning projections. In developing the distribution, DHS projected funding at a level which maintained SPA 8 at its current relative percentage level based on the 2008 Allocation Formula percentage. DHS then projected the available funds for SPAs 1, 3, 6 and 7 based on the amount which would increase their percent of funding to 71.5 percent of their 2008 Allocation Formula percentages. This methodology is similar to one included in the CCALAC recommendations. For SPAs 2, 4 and 5, DHS allocated the $1.0 million a year based on their relative percentages from the 2008 Allocation Formula. These planning estimates will change if additional funds are provided to qualifying SPA 2 projects to maintain SPA 2 at the 2008 Allocation Formula percentage. Actual funding percentages will depend on final approval of proposals submitted and qualifying for use of these funds.

DHS Report on Specialty Clinic Services

DHS has already undertaken a number of initiatives to improve access to, and manage demand for, specialty care services, which DHS believes will assist them in addressing issues related to the increase in primary care services proposed above.

In September 2007, DHS began countywide deployment of the Referral Processing System (RPS). RPS is a web-based system that allows DHS and PPP program providers to make electronic referrals to DHS referral centers for specialty care. DHS referral centers receive the electronic specialty care request and forward it to a clinician for clinical review. Approved requests are processed by the referral center where an appointment is scheduled and the patient is sent an RPS-generated appointment letter. After the patient is seen at the appointment the doctor's progress notes can be uploaded into the system where the original referring clinician can access them through the RPS site.

RPS has improved tracking and disposition of specialty care referrals, provides system wide information on the demand for specialty care, and improves the sharing of information between DHS and PPP providers and the return of the patient to their medical home. DHS plans to enhance RPS functionality by standardizing referral criteria across DHS facilities and specialty departments, imbedding standardized clinical prerequisite criteria into RPS, creating an upload of appointment data into RPS, providing users with expanded access to physician progress notes and other clinical information, and creating standard reports listing referral activity for users to access through RPS.

The DHS Healthy Way LA (HWLA) program includes a number of initiatives to manage the demand for specialty care and to improve access to care. HWLA provides health care coverage to low-income uninsured adult legal residents who receive care at DHS and PPP locations. Members are assigned to a medical home and receive expanded access to primary, preventive and specialty care services; urgent appointment access; 24/7 nurse advice line; member services; and care coordination services. The target population for HWLA includes individuals with chronic medical conditions such as hypertension, diabetes, congestive heart failure, asthma or chronic obstructive pulmonary disorder, or dyslipidemia.

The HWLA medical home provides members with primary care and preventive services and coordinates referrals to specialty care. Members with certain chronic medical conditions are referred to case management programs which emphasize disease management and providing care in the most appropriate venue. HWLA has supported the implementation of the ESS, for which the Workgroup has recommended $1.5 million in one-time funds.

HWLA has expanded specialty care services in both DHS and PPP locations. DHS has increased optometry, ophthalmology, and podiatry services in its non hospital-based ambulatory care network. Thirty-one PPP providers received HWLA funding to provide specialty care services including optometry, ophthalmology, podiatry, and cardiology.

In addition, the PPP Program agreements that went into effect on July 1, 2008 increased the number of PPP Program providers who received funding for specialty care in their base PPP agreement from two to six. Also in July 2008, DHS entered into agreements with 14 PPP providers in the MLK service area through the Strategic

Initiative Program which was implemented using SB 474 funding (South Los Angeles Medical Services Preservation Fund). Strategic Initiative Program providers had the option of using the funding for primary, specialty, or urgent care, either through direct service delivery or through infrastructure that leads to expanded capacity.

In September 2007 the Kaiser Permanente Community Benefit Program launched a specialty care grant initiative to fund 12-month planning grants to be followed by multi-year implementation grants. DHS is participating in five implementation projects funded in Los Angeles County. The five projects target different geographical areas. The purpose of the projects is to increase access and reduce demand for specialty care for the community's uninsured and underinsured populations. These projects are increasing the supply of specialty care, providing specialist training to primary care providers, and decreasing demand through better referral guidelines and improved communications between specialists and referring providers.

Attachments

PPP Recommendations Jan 2009

CCALAC RECOMMENDATIONS FOR USE OF ONE-TIME FUNDS FOR LA COUNTY'S PUBLIC PRIVATE PARTNERSHIP PROGRAM

On October 7th, 2008, the LA County Board of Supervisors instructed the Chief Executive Officer to reconvene the Public Private Partnership Allocation Workgroup to develop recommendations on the strategic use of:

- $4.8 million in infrastructure dollars in under-equity Service Planning Areas (SPAs), and
- $40 million to address PPP inequity in under equity SPAs and other underserved areas of the County.

Further, the Board moved that the Workgroup recommend strategies for improving coordination of care—including the creation of medical homes, especially for frequent users of emergency room services, and strategies on how the use of these funds can be implemented, monitored, and overseen to ensure accountability and encourage best practices.

CCALAC represents the non-profit community and free clinics that operate primary care sites throughout LA county, including all 33 of the PPP Strategic Partners. The association strives to identify and address the collective needs of our members at the local, state and federal levels. To appropriately respond to the request of the Board of Supervisors, CCALAC worked with our members to develop recommendations on the response to the Superviors' motion.

Through the Association's Compensated Care and Public Policy Advisory Group and the membership meetings, CCALAC engaged our members in a dialogue regarding these recommendations. It was a challenge for members to address past funding inequities while being strategic about new challenges, in particular given the limited amount of funding available. **The following recommendations reflect a majority consensus of CCALAC's members regarding how the PPP funding and Supervisors' motion should be addressed**:

BOARD MOTION: SET ASIDE $4.8 MILLION TO ESTABLISH NEW CLINIC SITES IN UNDER-EQUITY SPAS, TO BE SPENT BEFORE THE REMAINING FUNDS ARE DISTRIBUTED.

PPP clinics have leveraged federal and private funds to expand sites and services for the underserved. Over the past five years, community clinic organizations across LA county have made major strides in adding additional sites and services: clinics within CCALAC's membership have added 27 clinic sites, increased the number of sites with Federally Qualified Health Center designations by 23, and those with Look-Alike designation by 11. Five organizations are new Section 330 FQHC grantees with applications pending for 11 sites.

Clinics have made significant expansions countywide in the past five years, and have plans underway to create additional sites:

CCALAC Members Current and Planned Sites[1]

SPA	Sites June 2008	Increase Since 2003	Planned Sites
1	**3**	**-**	**1**
2	26	7	3
3	**8**	**2**	**3**
4	40	7	3
5	6	-	1
6	**14**	**1**	**3**
7	**16**	**4**	**1**
8	**16**	**6**	**4**

While the number of access points has increased in the past five years, the amount of PPP funding for services has not increased to fill the capacity created with these new access points. **With no significant increase in their organizational maximum contract obligations, clinics simply split their PPP funding between old and new sites in order to create access for the PPP program at these new locations.**

CCALAC RECOMMENDS THAT THE COUNTY:

Follow the input from PPPs given in prior PPP Allocation Methodology Workgroup convenings:

- ***Allow for expanded capacity at current sites because:***
  - ***Current sites are already in high-need areas and need investments in order to improve and increase services.***
  - ***Expansions at current sites are less costly than creating new sites, and usually allow for speedier increases in access to services.***
- ***Make funding flexible to allow providers to best suit expansions to their patient population and service area.***
- ***Invest in provider efficiencies and improved practices which improve the coordination of care as required by another portion of the motion. SB474 and the Cedillo Alarcon Community Care Investment Act provide examples.***
- ***Leverage funding for new sites, where possible.***

BOARD MOTION: SET ASIDE $40 MILLION IN ONE-TIME FUNDS TO ADDRESS PPP INEQUITY IN UNDER-EQUITY SPAS OVER A THREE-YEAR PERIOD, INCLUDING REPLICATING SUCCESSFUL MODELS AND LEVERAGING ADDITIONAL OUTSIDE FUNDING. ADDITIONALLY, CONSIDER AREAS OF THE COUNTY THAT ARE UNDERSERVED.

The PPP Allocation Methodology Workgroup developed a methodology to address the funding inequities between the Service Planning Areas. The methodology was agreed upon by the PPP

[1] CCALAC LA County 330 Expansion Planning Report June 2008. Under-Equity SPAs bolded/highlighted. Note: since June 2008, one planned site in SPA 3 has officially opened.

providers, LADHS and the County CEO in the recommendations presented to the Board in April of 2008.

The PPP allocation methodology estimates the "unmet need" among low-income uninsured in the county, which is Total Need – Supply. The final result is a percentage of total countywide need, which is then compared to the SPA's share of county PPP funding. For example, SPA 3, according to the Methodology, bears 20.36% of the share of the county's unmet need, yet receives only 13.35% of the funding allocation.

The SPA allocation methodology provides a beginning measure by which to address inequities in relative funding across large geographic areas. This does not assume that the total level of funding countywide, or in any Service Planning Area, is adequate to address the unmet need of that area. Indeed, certain pockets at the sub-SPA level may have a high level of unmet need and little PPP resource investment. The Workgroup must also provide recommendations on addressing these pockets of poverty and need. One suggestion from the Board of Supervisors was to consider the federal Health Resources and Services Administration Health Professional Shortage Area (HPSA) designation as an indicator of need. HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas (Geographic Area HPSA), population groups (Population Group HPSA) or medical or other public facilities (Facility HPSA). All Federally Qualified Health Centers (FQHCs) including FQHC Look-Alikes receive automatic facility HPSA status. **Each FQHC is HPSA-designated as an entity, encompassing all service locations included in the approved scope of work. As of October 2008, Congress passed legislation to make Automatic Facility HPSAs *permanent designations*.** This designation does not expire.

Several geographic areas, such as Medical Service Study Areas (MSSAs), census tracts and zip codes, are sub-SPA areas at which disproportionate need can be assessed. Factors that may indicate a sub-SPA area is underserved include poverty and coverage indicators and clinic-level data. The following recommendations do not include a methodology for identifying sub-SPA pockets of need, but do offer considerations for this funding.

CCALAC RECOMMENDS THAT THE COUNTY:

- ***Address Service Planning Area inequities by allocating 75% of the one-time funds to SPAs 1, 3, 6, 7, and 8 over three years, allocating $10 million each year. Address disproportionate need at the Sub-SPA level by allocating 25% of the one-time funds ($10 million) to SPAs 2, 4 and 5 over 3 years, allocating $3.33 million each year.***
- ***Select a funding mechanism that will get resources allocated and distributed <u>within 90 days</u> of Board motion to providers.***
- ***Allow for sustainable capacity increases in areas receiving funding, and for ramp-up of services over the three year period.***
- ***Ensure that the methodology for distributing this funding not be used for future allocations beyond this three year period. The funding methodology and the dialogue for its creation should inform future discussions on how best to build a system of care that meaningfully captures the needs of the entire county. While the investment is not enough to bring the system to full equity, this one-time funding***

should serve to help stabilize a system out of balance, and set it towards improved sustainability.

- ***Plan for sustainability in the out-years, beyond the three-year time frame of this funding.***
- ***SERVICE PLANNING AREA INEQUITIES ($30 million over 3 years):***[2]
  Address Service Planning Area inequities by allocating 75% of the one-time funds to SPAs 1, 3, 6, 7, and 8 over three years, allocating $10 million each year utilizing the SPA Allocation Methodology. At the current reimbursement of $94 per visit, this investment will allow for the expansion of 319,148 visits in these SPAs.
  - ***The distribution of this funding should capture the degree of unmet need in each SPA and bring each SPA toward their equitable allocation.***
  - ***By targeting 75% of the funds over three years, 65.11% of the shortfall in each of the under equity SPAs can be addressed. See the attachment "SPA Allocation Scenarios" for a discussion of CCALAC's recommended allocation scenario.***
- ***SUB-SPA INEQUITIES ($10 million over 3 years):***
  Address disproportionate need at the Sub-SPA level by allocating 25% of the one-time funds ($10 million) to SPAs 2, 4 and 5 over 3 years, allocating $3.33 million each year. At the current reimbursement of $94 per visit, this investment will allow for the expansion of 106,383 visits in these sub-SPA areas.
  - ***Geographic area: Medical Service Study Areas (MSSAs), census tracts and zip codes are sub-SPA areas at which disproportionate need can be assessed.***
  - ***Factors of need: start with poverty indicators, and allow providers flexibility to make the case with clinic-level data.***
  - ***Allow for consideration of how providers serve these areas. Also consider language and cultural barriers to access, such as for the homeless and GLBTQ populations.***
  - ***Encourage collaboration among providers serving high need areas.***
  - ***RFAs such as the SB 474 South Los Angeles Strategic Initiative RFA provide an example of how the county can tie expansions in services to a particular area of need.***[3] ***In the example of SB474, the clinics' workplans involve the tracking of patients served by zip codes of residence in order to demonstrate the increase in services for that particular patient population. In addition, clinics were encouraged to submit collaborative proposals.***

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[2] ***Note:*** any funding increase to the under-equity SPAs has an impact on the relative equity of the at-equity SPAs. For example, the investment of $30 million into the under-equity SPAs pushes the SPA 2's share of total funding from 17.29% to 14.52%, two points below its equity allocation of 16.78%. Because the relative level of current funding may cause a SPA to be only slightly over or under the equity threshold, it is important to note how total funding impacts equity across the County.

[3] SB 474 RFA is provided as an attachment to this document.

BOARD MOTION: RECOMMEND STRATEGIES FOR IMPROVING COORDINATION OF CARE—INCLUDING THE CREATION OF MEDICAL HOMES, ESPECIALLY FOR FREQUENT USERS OF THE EMERGENCY ROOM SERVICES.

Care coordination is the hallmark of community clinics and health centers, and a central tenet of the PPP program. As documented separately with the Allocation Workgroup, the PPPs currently engage in a wide number of activities to improve care coordination:

- Technology improvements reduce duplication of services, improve access to clinical data, and improve coordination across providers.
- Chronic disease management activities improve the collection and tracking of patient health indicators to better manage chronic diseases such as asthma, hypertension and diabetes.
- Specialty care coordination facilitate better screening and referrals, and improved access to these services.
- Frequent user programs decrease inappropriate utilization of the ER through the creation of medical homes, and improve coordination of services between clinics and hospitals.

PPP providers combine resources to improve the health outcomes of the underserved. The PPP Program serves a high number of adults with chronic disease, who might otherwise use the emergency room for care. Adults with asthma, diabetes, hypertension or a lipid/cholesterol problem account for 40% of all PPP users.[4] PPP users with chronic diseases made an average of 4.6 visits per year compared with an average of 2.1 visits for PPP users without these chronic diseases.[5] This finding points to the importance of the PPP Program as an effective system for preventing morbidity and mortality, including the overuse of emergency rooms and hospitals.

CCALAC RECOMMENDS THAT THE COUNTY:

- ***Support current efforts at coordination of care utilizing some portion of the $4.8 million. Do not start new initiatives that would duplicate efforts already underway.***
- ***As part of the $4.8 million in infrastructure funding, allow providers to use their funds for efficiencies and improved practices which improve the coordination of care. SB474 and The Cedillo Alarcon Community Care Investment Act provide examples of such investments.***

BOARD MOTION: RECOMMEND STRATEGIES ON HOW THE USE OF THESE FUNDS CAN BE IMPLEMENTED, MONITORED, AND OVERSEEN TO ENSURE ACCOUNTABILITY AND ENCOURAGE BEST PRACTICES.

The members of CCALAC believe that the intent of the Public Private Partnership (PPP) was to begin to build a system of primary care for the indigent in Los Angeles County. While the program has been very successful the system remains fragmented. We believe strongly that an oversight body should be established that expands on the partnership between the County and the community clinics to include other private stakeholders in the planning, development, monitoring and oversight of the resources and programs that are needed to establish a coordinated system of primary care for the low income members of our community.

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[4] Darryl Leong, MD. *The Power of Partnership: Solutions Created and Lessons Learned by the Public Private Partnership*, Prepared for CCALAC, May 2005.

[5] Ibid.

This new body would be comprised of representatives of the Board of Supervisors, appropriate County departments, the private sector including the PPPs, and other key non-county organizations. The members would be appointed by the Board of Supervisors and would assume governance and administrative responsibility for developing and implementing a plan for community centered primary care service delivery that maximizes current resources while identifying short and long term strategies for attracting new revenues.

There are far too many residents of Los Angeles relying on us to address their need for access to quality, coordinated, culturally appropriate health care. Without an adequate primary health care system that strives to keep people healthy and out of the emergency rooms, the entire system will collapse.

ADDITIONAL CONSIDERATIONS / FUTURE CONCERNS

Each Service Planning Area in LA County has areas of high need for health care services, and there is not sufficient funding in any area of the County to adequately meet this need. The investment that the Supervisors' have made will make strides in stabilizing the safety net of community clinics over the next three years.

In addition to the above recommendations related to the motion and the 3 year timeframe of this funding, CCALAC also offers the following recommendations for consideration beyond this current dialogue.

CCALAC RECOMMENDS THAT THE COUNTY:

- ***Enhance the reimbursement rate to enable the PPPs to keep up with the increasing costs of delivering health care services. With the downturn in the economy, PPPs will find it increasingly difficult to raise funds to offset the cost of caring for PPP patients.***
- ***Create a plan for fully stabilizing the PPP program beyond the three-year timeframe of this funding. This will allow for a longer range vision of health care in LA County.***

ATTACHMENT:
SPA ALLOCATION SCENARIOS

The SPA Allocation Methodology estimates the "unmet need" among low-income uninsured in the county across Service Planning Areas: Unmet Need = Total Need – Supply. The need is the number of residents by SPA who are uninsured and below 200% FPL, multiplied by expected primary care utilization rates (age-adjusted). The supply is calculated by the number of visits by SPA made by residents who are uninsured and below 200% FPL at DHS facilities, Licensed Clinics, Hospitals and Health Centers). The final result is a percentage of total countywide need, which is then compared to the SPA's share of county PPP funding. For example, SPA 3, according to the Methodology, bears 20.36% of the share of the county's unmet need, yet receives only 13.35% of the funding allocation.

The following tables show two scenarios for annually allocating funds across the "under-equity" SPAs. To best work toward equity in the proportional allocation of PPP funds, **CCALAC recommends that the county utilize the second scenario.**

Scenario 1: Distributing $40 million strictly according to percentage of unmet need.
We take a strict interpretation of the methodology and simply divide the $40 million between the under-equity SPAs according to their calculated unmet need:

- We divide $40 million by each SPA's percentage calculated unmet need (column B), and further divide this by three to find each SPA's share of the $40 million (column G).
- Next we add this amount to the FY 2008-08 allocation for that SPA (column E), to determine the SPA's new total allocation (column H).

Simply dividing the funds between under-equity SPAs in this manner will cost $9,686,667 per year. The impact on equity to each SPA will vary depending on its current share of countywide PPP funding (column C), and the SPA's shortfall to its equity allocation (column F). For example, this approach would provide SPA 8, which bears 13.21% of the unmet need, with $1,761,333, $651,653 more than its shortfall from equity of $1,109,680. Under this scenario, the total percentage shortfall from equity is reduced from 30.32% to 21.06%, a 9.26 point drop.

Scenario 2: Distributing $40 million equitably across percentage shortfall
In the second scenario we attempt to bring each SPA up an equal distance toward its equity allocation using a similar level of funding required in the first scenario, $10 million per year:

- We divide $10 million by the total shortfall to equity distribution of $15,359,530.61 (column F). This shows that a $10 million investment will bring the countywide equity shortfall 65.11% closer to the equity allocation.
- We then calculate 65.11% of the shortfall to equity for each SPA, to determine the amount required to each SPA an equal distance toward its equity distribution (column G).
- Next we add this amount to the FY 2008-09 allocation for that SPA (column E), to determine the SPA's new total allocation (column H).

Unlike in the first scenario, under this methodology the impact on equity to each SPA is controlled so that it takes into account the funding the SPA currently receives and its shortfall from equity. The impact to the countywide percentage shortfall from equity under this scenario is

a 9.49 point drop in the percent shortfall, from 30.32% to 20.83%. Compared to the first allocation scenario, this option offers a .23 point greater impact on equity.

NOTE: any funding increase to the under-equity SPAs has an impact on the relative equity of the at-equity SPAs. For example, the investment of $30 million into the under-equity SPAs pushes the SPA 2's share of total funding from 17.29% to 14.52%, two points below its equity allocation of 16.78%. Because the relative level of current funding may cause a SPA to be only slightly over or under the equity threshold, it is important to note how total funding impacts equity across the county.

Allocation Scenario #1: Distributing $40 million to Under-Equity SPAs strictly according to umet need[6]

A	B	C	D	E	F	G	H	I	K
SPA	2008 Allocation Formula (Unmet Need)	% Allocation 2008/09	% Point Shortfall	FY2008/09 Allocation	Shortfall from Equity Distribution of FY2008/09 Allocation	Allocation of $40 million funds by unmet need	New Total Allocation	% Total Allocation FY08/09 With Additional Allocation	Final % Point Shortfall with $10m
1	*2.49%*	0.82%	1.67	$415,674	$845,664.26	332,000	*$747,674.00*	1.24%	1.25
2	*16.78%*	17.29%		$8,760,792			$8,760,792	14.52%	2.26
3	*20.36%*	13.35%	7.01	$6,762,854	$3,550,739.16	2,714,667	*$9,477,520.67*	15.71%	4.65
4	*10.98%*	32.26%		$16,343,297			$16,343,297	27.08%	-16.1
5	*-0.40%*	8.11%		$4,109,900			$4,109,900	6.81%	-7.21
6	*18.40%*	8.41%	9.99	$4,259,639	$5,061,093.52	2,453,333.33	*$6,712,972.33*	11.12%	7.28
7	*18.19%*	8.73%	9.46	$4,422,001	$4,792,353.59	2,425,333	*$6,847,334.00*	11.35%	6.84
8	*13.21%*	11.02%	2.19	$5,581,998	$1,109,680.08	1,761,333.33	*$7,343,331.33*	12.17%	1.04
Total	*100%*	100.00%	30.32	$50,656,155	$15,359,530.61	9,686,667	$60,342,821.33	*100%*	21.06

[6] **NOTES:**

- **Column F** shows the shortfall each SPA had from their equitable distribution of FY2008-09 funding according to unmet need.
- **Column G** specifies the allocation each SPA would receive under this scenario.
- **Column I** shows the new percentage of the total funding the SPA would received with the additional allocation.
- **Column D** shows the percent point shortfall to each SPA's equity distribution prior to distributing the new funding.
- **Column K** shows the new percent point shortfall to each SPA's equity distribution after distributing the new funding.

Scenario #2: Distributing $30 million ($10 milion) per year to Under-Equity SPAs equitably across percentage shortfall[7]

A	B	C	D	E	F	G	H	I	J	K
SPA	2008 Allocation Formula (Unmet Need)	% Allocation 2008/09	% Point Shortfall	FY2008/09 Allocation	Shortfall from Equity Distribution of FY2008/09 Allocation	Allocation of $10m	Total Allocation FY08/09 With $10m	% Total Allocation FY08/09 With $10m	% Shortfall Made Up With $10m	Final % Point Shortfall with $10m
1	*2.49%*	0.82%	1.67	$415,674	$845,664.26	$550,579.49	*$966,253.49*	1.59%	*65.11%*	0.90
2	*16.78%*	17.29%		$8,760,792			*$8,760,792.00*	14.44%		2.26
3	*20.36%*	13.35%	7.01	$6,762,854	$3,550,739.16	$2,311,749.79	*$9,074,603.79*	14.96%	*65.11%*	5.40
4	*10.98%*	32.26%		$16,343,297			*$16,343,297.00*	26.94%		-16.1
5	*-0.40%*	8.11%		$4,109,900			*$4,109,900.00*	6.78%		-7.21
6	*18.40%*	8O.41%	9.99	$4,259,639	$5,061,093.52	$3,295,083.46	*$7,554,722.46*	12.45%	*65.11%*	5.95
7	*18.19%*	8.73%	9.46	$4,422,001	$4,792,353.59	$3,120,117.22	*$7,542,118.22*	12.43%	*65.11%*	5.76
8	*13.21%*	11.02%	2.19	$5,581,998	$1,109,680.08	$722,470.04	*$6,304,468.04*	10.39%	*65.11%*	2.82
Total	*100%*	100.00%	30.32	$50,656,155	$15,359,530.61	$10,000,000.00	$60,656,155.00	*100%*	*65.11%*	20.83

[7] **NOTES:**

- **Column F** shows the shortfall each SPA had from their equitable distribution of FY2008-09 funding according to unmet need.
- **Column G** specifies the allocation each SPA would receive under this scenario.
- **Column I** shows the new percentage of the total funding the SPA would received with the additional allocation.
- **Column D** shows the percent point shortfall to each SPA's equity distribution prior to distributing the new funding.
- **Column K** shows the final percent point shortfall to each SPA's equity distribution after distributing the new funding.

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Preliminary Feedback and Executive Summary

KEY INFORMANT INTERVIEWS

DRAFT – FOR DISCUSSION ONLY – December 17, 2008

Introduction

The Public-Private Partnership Program [PPP] Workgroup was charged with developing a set of recommendations to the L.A. County Board of Supervisors on how to most effectively allocate $44.8 million in new one-time primary care funding pursuant to a unanimously approved Board motion on October 7, 2008.

The California Endowment independently contracted with Bobbie Wunsch, Partner with Pacific Health Consulting Group, to interview 18 state and nationally recognized primary care experts and other key informants to gather their thoughts on how these funds could be most effectively spent. The preliminary results are summarized below. A full version of the report will be completed and available in early January 2009.

The experts both provided overall guidance concerning the broader economic and political environment within which the work group must develop its recommendations and suggested specific, concrete ways to use the funding. Most of the individuals interviewed were not familiar with the details of the PPP program and therefore offered broader feedback. These specific ideas largely fell within three categories: (1) investing in technology and infrastructure; (2) implementing new models of care delivery; and (3) realigning funding incentives. We have included a list of those interviewed to date as well as the questions that were asked (Attachments A and B).

General Guidance

Respondents encouraged the County to consider decisions about allocating the one-time funds in the broader context of potential efforts towards establishing a national health coverage program led by President-elect Obama. Safety net providers must be ready for reform because the most viable national reform plans under discussion rely heavily on the expansion of Medicaid, Medicare, SCHIP and other public programs. A number of respondents suggested allocating the one-time funding in a way that moves the PPP clinic system towards embracing models that will likely be incorporated in any reform at the federal level (e.g. pay for performance, prevention, electronic transfer of information, medical homes, better alignment of funding incentives).

In counterpoint to the optimism around national health reform, respondents also cited the severe economic downturn as a barrier to implementing some potential system improvements. For example, implementing some of the suggested technology and delivery systems changes will be challenging, as many clinics will likely be coping with a spike in demand for services from uninsured residents which may constrain their ability to adopt new delivery models and technology.

Many respondents pointed out that demand for services at community clinics in aggregate will always exceed supply. Using the one-time funding as an investment in improving efficiency will allow clinics to maximize the services they can provide, given the uncertain and fluctuating funding streams that they rely on for ongoing operating support. Respondents also cautioned that substantial investment in training and workforce development will be necessary to incorporate any of the strategies for system improvement suggested during the interviews.

Respondents also cited the importance of evaluating the outcomes associated with the investment of the $44.8 million. The funding should be contingent on achievement of specific, measurable and realistic goals and incentives should be structured into the program to encourage PPP clinics to meet their goals.

Some respondents who are familiar with the current PPP network cited challenges in the organization and management of the PPP program. Recently, key staff vacancies at DHS have left the program without steady leadership and a clearly defined direction. To address these issues, respondents suggested improvements in strategic planning and oversight of the PPP program at the county government level, and more collaboration and resource sharing among PPP clinics.

Specific Suggestions

1) Invest in technology and capital infrastructure:

Investment in technology infrastructure was the most common issue raised by the respondents. For those familiar with the LA County PPP program, there was a sense that the LA County primary care system has lagged behind other regions in the implementation of technology. In particular, a clear opportunity exists for expanding the electronic transfer of information through a variety of techniques. Other California counties have experienced significant success on this front.

For example, Alameda County has made significant advances with its One-e-App technology, which is still in limited use in L.A. County. In addition, Orange County has made progress in the implementation of a web-based data repository that can be shared by providers across its health system through its MSI program for indigent care with ClinicConnect for all participating clinic providers and EConnect for its emergency

room providers. In San Francisco providers have had success with specialty care e-referrals. These practices are in limited use in L.A. County.

A common suggestion around technology was the implementation of disease registries. Respondents acknowledged the challenges of moving towards a full-fledged electronic health records (EHR) system, but agreed that this should be the long-term goal. Comprehensive disease registries would be the logical first step in this process. Technological Innovations such as telemedicine were also mentioned as ways to improve efficiency. Many respondents stressed that technological innovations must be directed at sharing information across the entire PPP program, in order to achieve results in improving quality of care.

Should the funding go to technology improvements, there was a consensus among respondents that it be contingent on meeting certain technological benchmarks that have been proven to increase clinic effectiveness and quality of care. Given that the funding will be allocated over three years, incentives could be built in that require the implementation of disease registries and establishment of a timeline for other technological advances that help clinics make progress towards implementing EHRs. The funding could be staggered over the three years with distribution contingent on making progress towards EHR implementation.

Aside from technology, respondents also identified a need for more traditional "bricks and mortar" investments in infrastructure. Some suggested using the PPP funding to create incentives to increase capacity in underserved areas. For example loans could be set up to create new clinic sites, which would be forgiven if the clinic succeeded according to outcome measures attached to the funding. Other respondents suggested using the funding to expand existing clinics in high-need areas to improve capacity. However, whether the funding is used for technology or traditional bricks and mortar infrastructure, several of the experts cautioned that $4.8 million would provide limited impact across such a large system and that a larger proportion of the funds should be considered for infrastructure.

2) Modernize clinics by implementing new models of care delivery:

Many respondents suggested using the funding to improve coordination of care by PPP clinics, by implementing newer, more effective models of patient care delivery within clinics and across the safety net provider system. The high rate of chronic disease in the patient population served by clinics in the PPP program necessitates the implementation of innovative models for chronic disease management by providers. The most common practices cited included:

- Implementing chronic disease management programs and disease registries:
  - Including population management, protocol based regulation of medication, attention to treatment guidelines, self-management support and intensive follow-up.

- Care coordination combined with regular on-going care from the same provider:
  - For those patients who treat the clinic as a medical home, a team of providers assigned to a patient could include a primary care physician or nurse practitioner, nurse or medical assistant, nutritionist, health promotora and/or social worker.

- Integrating behavioral health services into primary care settings:
  - Having mental health providers available at clinics to work with primary care providers to address the physical and mental needs of a patient.

- Easier access:
  - Offering same day appointments and expansion of evening and weekend hours to meet needs to patients as well as implementation of group visits and nurse advisors or nurse advice lines.

In addition, some respondents also cited the following best practices that PPP clinics should consider replicating:

- Panel management programs
  - Allows the systematic review of an entire population of patients with the same chronic disease. Panel management attempts to address chronic care needs outside of a face-to-face office visit. Many of the tasks can be performed by a Panel Management Assistant which frees up time for physicians to address more urgent patient needs.

- Physician extenders
  - Shifting more responsibility for patient care to nurse practitioners and physician assistants, freeing up time for primary care providers to see patients with more urgent conditions.

Although many of these practices are currently being implemented within participating PPP clinics, respondents felt that this new funding could help to standardize and institutionalize these practices on a system-wide scale across the PPP program. Again respondents suggested that incentives be established to encourage the implementation of these best practices and suggested that the PPP program look at how managed care plans have incentivized these practices.

3) Realign payment incentives, leverage funding to help clinics stay viable in the future:

Many respondents cautioned against using this one-time funding for direct services to patients out of concern that such funding would create an expectation of ongoing care among the new patients served, when funding after the three year period is uncertain. This concern was heightened given the significant budget deficits facing state and local governments. Respondents stressed the importance of identifying opportunities to leverage these one-time funds to improve sustainability of the PPP clinics. For example, respondents suggested that the county could leverage public funds with existing philanthropic efforts to improve local primary care. Leveraging opportunities cited in interviews included:

- Building Clinic Capacity for Quality (BCCQ): A learning collaborative to support the implementation of quality improvement initiatives that are supported by health information technology.
    - Funded by: LA Care Health Plan, Blue Shield Foundation/Kaiser, UniHealth Foundation

- Capital improvement project loan fund for capital expansions for LA County clinics: The funding will support technical assistance for the planning of infrastructure expansion projects as well as provide loans with favorable terms.
    - Funded by: California Community Foundation

- Tools for Quality: Statewide initiative providing funding and training for implementation of chronic disease management systems in community clinics. The first patient population of focus is diabetes.
    - Funded by: Tides Foundation, The California Endowment, California Health Care Foundation, Blue Shield of California Foundation, Kaiser Permanente

- Accelerating Quality Improvement Through Collaboration (AQIC): Statewide collaborative quality improvement project focused on coordination of quality improvement measures and implementation strategies.
    - Funded by: The California Health Care Foundation

- Specialty care planning grants for Los Angeles County: Each Service Provider Area (SPA) was awarded $300,000 in planning grants.
    - Funded by: Kaiser Permanente

Respondents also cited the challenges of the current per visit fixed fee reimbursement model for clinic services that does not encourage providers to adopt practice innovations such as panel management, case management and integrated care. Often the respondents suggested adoption of managed care reimbursement techniques for those chronically ill patients that use a clinic as a medical home (per-member-per-

month, per-case, or per-user payment structure). This structure should also be accompanied by pay for performance incentives; a payment structure that rewards health care providers for meeting certain performance measures for quality and efficiency.

Some respondents suggested that PPP clinics be expected to leverage these new county funds with other matching funding to expand the potential of the funding and not to supplant other funding sources. The experts also encourage a continued focus on expanding FQHC and FQHC look-alike status among clinics in the PPP program in order to maximize federal and state reimbursement.

Methodology

The initial planning of the project focused on identifying the leading primary care experts locally and nationally. The interviewees were selected with the goal of capturing a variety of expertise within the field of primary care. The selection of the questions sought to strike a balance of providing opportunities for respondents to provide general thoughts and comments while also containing specific questions that attempted to inform the guidelines outlined in the Board motion. The members of the workgroup provided suggestions on appropriate individuals to be interviewed as well as feedback on the list of questions. Both the interviewee list and the list of questions are attached (Attachment A and B).

The interviews were conducted over the course of three weeks beginning in mid November. We were able to complete interviews with 18 of the 19 interviewees initially identified. Each interview lasted approximately one hour and they were recorded to ensure that their comments were captured accurately. To encourage open and honest feedback, no specific recommendations or comments included in the report have been attributed to the interview subjects. Each interview was summarized and then analyzed to draw out the major recommendations from respondents which have been compiled in the preceding executive summary.

Respondents also referenced several reports on successful implementation of technology infrastructure and care delivery improvement models that are listed in the attached bibliography (Attachment C).

Attachment A

Interviews conducted by Bobbie Wunsch, Pacific Health Consulting Group, from November 13, 2008 through December 12, 2008.

First Name	Last Name	Title	Affiliation	Date
Dr. Thomas	Bodenheimer	Adjunct Professor	UCSF Dept. of Family and Community Medicine	11/24/2008
Allison	Coleman	Chief Executive Officer	Capital Link, Inc.	11/21/2008
Jonathan	Freedman	Chief Deputy	Department of Public Health, LAC	12/8/2008
Robert	Gates	Deputy Agency Director	Orange County Health Care Agency	12/9/2008
Laura	Hogan	Vice President of Program	The California Endowment	11/20/2008
Bridget	Hogan Cole	Program Director	Building Clinic Capacity for Quality	12/12/2008
Howard	Kahn	Chief Executive Officer	LA Care Health Plan	11/13/2008
Kathy	Ko[i]	Program Director	Tides Foundation-Community Clinics Initiative	11/20/2008
Ingrid	Lamirault	Chief Executive Officer	Alameda Alliance for Health	11/14/2008
Dr. Sharon	Levine	Associate Executive Director	The Permanente Medical Group, Inc.	12/8/2008
Karen	Linkins	Consultant	Evaluator of the Frequent Users of Health Initiative	11/25/2008
Lisa	Mangiente[ii]	Consultant	Alameda Net	11/25/2008
Barbara	Mauer	Managing Consultant	MCPP Consulting	11/25/2008
Ed	O'Neill	Director and Professor	UCSF Center for the Health Professions	11/21/2008
Kathy	Reynolds	Chief Executive Officer	Washtenaw Community Health Organization	12/9/2008
Melissa	Schoen[iii]	Senior Program Officer	California Healthcare Foundation	12/12/2008
Ralph	Silber	Executive Director	Alameda Health Consortium	12/9/2008
Tony	Skapinsky[iv]	Project Consultant	Capital Link, Inc.	11/21/2008
Dr. Mark	Smith	President and CEO	California Healthcare Foundation	12/12/2008
Jane	Stafford	Senior Program Officer	Tides Foundation-Community Clinics Initiative	11/20/2008
John	Wallace	Chief of Staff	LA Care Health Plan	11/21/2008
Tara	Westman	Director of Grants Program	Weingart Foundation	12/8/2008

[i] Participated with Jane Stafford, Senior Program Officer , Tides Foundation-Community Clinics Initiative
[ii] Participated with Karen Linkins, Consultant, Frequent Users Initiative Evaluator
[iii] Participated with Mark Smith, President and CEO, California Healthcare Foundation
[iv] Participated with Allison Coleman, Chief Executive Officer, Capital Link, Inc.

Attachment B

QUESTIONS FOR KEY INFORMANTS

1. Based on your knowledge of the PPP Program, do you have ideas about how we can achieve and regularly document the outcomes of the program including patients seen as well as patients' health status?

2. Are there emerging and new models of delivering primary care and innovations that improve quality and create cost efficiency that we should consider supporting?

3. What can be learned from other funding allocation processes that you are familiar with or have experience with? Have any of those processes included a shift in allocation over time to account for changes in need? Are there experiences from other settings or other jurisdictions that we should research?

4. What policy initiatives are you aware of that hold promise for creating stable safety net care systems?

5. Are there other states or locales that we should look to for their innovation in this area? In funding allocation, in new models, in policy initiatives?

6. What have you seen as the missed opportunities in funding and strengthening outcomes in programs like LA's PPP/DHS program?

7. What barriers impede making needed changes? What needs to be done to overcome them?

8. How can the infrastructure of providers be strengthened in this process (especially in very underserved or under-equity areas)? What are the most effective ways of doing this with outside funding?

9. What training and infrastructure would need to be in place to implement and oversee your recommendations?

10. What recommendations do you think the working group should make to the Board of Supervisors regarding how it should spend the $44.8M dollars over three years. (Ask for at least three very specific and doable recommendations).

11. What policy changes must be implemented for long term financing of these recommendations? (Ask for any studies that have analyzed the patient outcomes/impacts of implementing these and other recommended changes).

12. Given the recent changes in the political and fiscal environment, what additional considerations should we make in forming these recommendations?

13. Are there any individuals within the County who should be tapped to work more closely w/PPPs to create clinical pathways for specialty care?

14. Do you have any specific recommendations for strengthening the infrastructure of PPP providers in South, East LA and Antelope Valley?

15. How can we ensure that the county best coordinates the need for additional specialty care services?

16. What recommendations do you have to improve the county's strategic planning, oversight and monitoring of the PPP program in the future?

    a. Should new oversight models be considered?
    b. Should additional community and stakeholder involvement be solicited? If so, in what form?
    c. Are there additional opportunities to collaborate among public and private providers?
    d. Are there strategies to encourage the use of evidence-based planning in the administration of the PPP program going forward?

Focused questions for Emergency Room Frequent Utilizer (FU) Expert:

1. How much time was needed to plan projects? Who needs to be at the table? What were the costs? What was the size of the planning grants?

2. Were successful projects the outgrowth of other collaborations in communities? What were those? Are there key factors that need to be in place?

3. What should LAC try to replicate?

4. What training/expertise is needed?

5. Who would you recommend as a program design consultant?

6. What were the elements that led to the successful cooperation of DMH/DHS?

7. Is there further analysis of LAC that could be shared about challenges faced? Are there LAC specific recommendations that are not included in the evaluation?

8. If LAC were to implement a regional pilot, what advice would you give?

Attachment C

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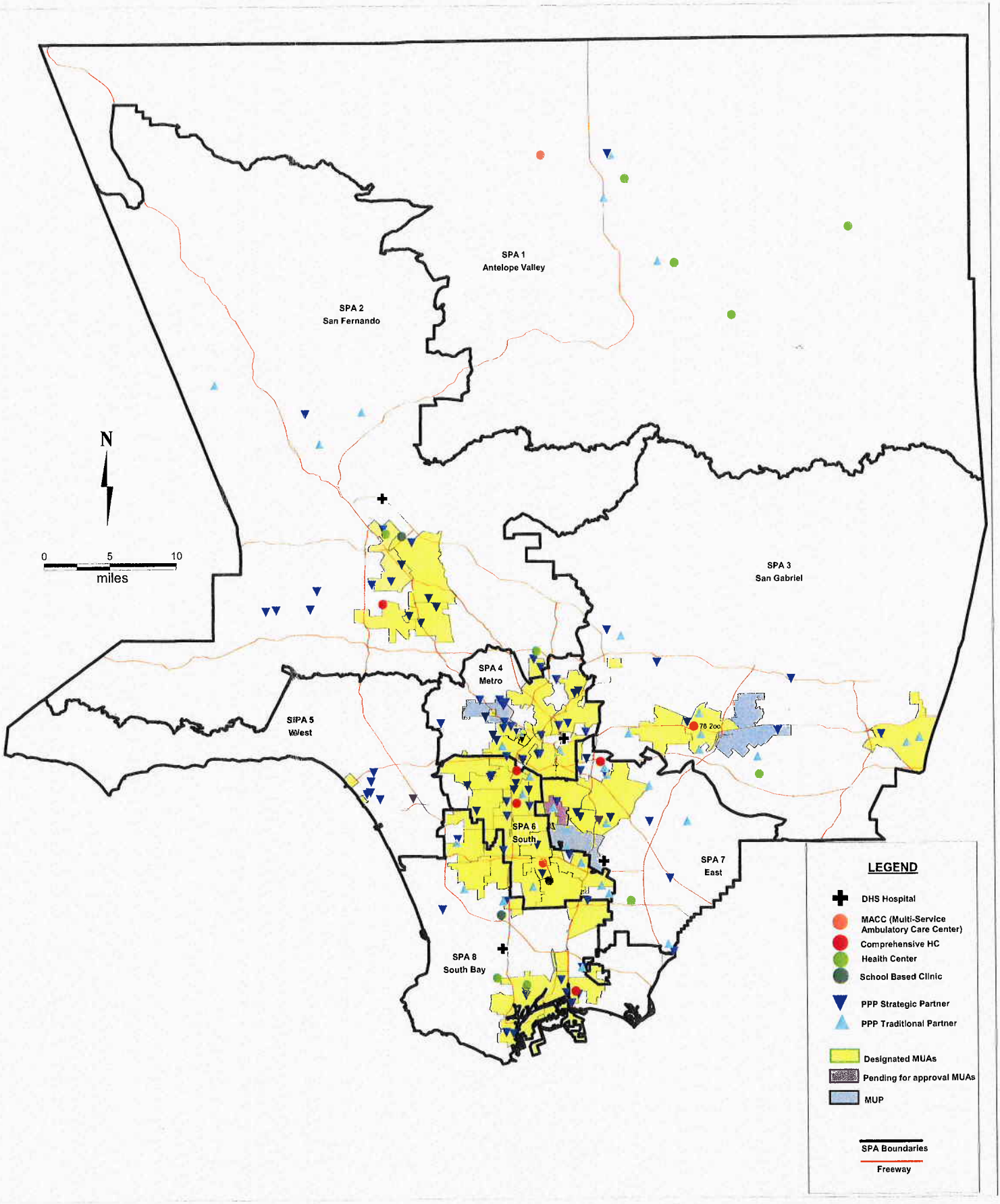
6. Mauer, Barbara. "Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home." MCPP Healthcare Consulting The National Council for Community Behavioral Healthcare: October 2, 2008 (Draft not yet distributed)

7. "Reducing Patient Wait Times." Primary Care Development Corporation: Excellent Healthcare in Every Neighborhood. http://www.pcdcny.org/programs/operations_success/patient_visit.html

Attachment III

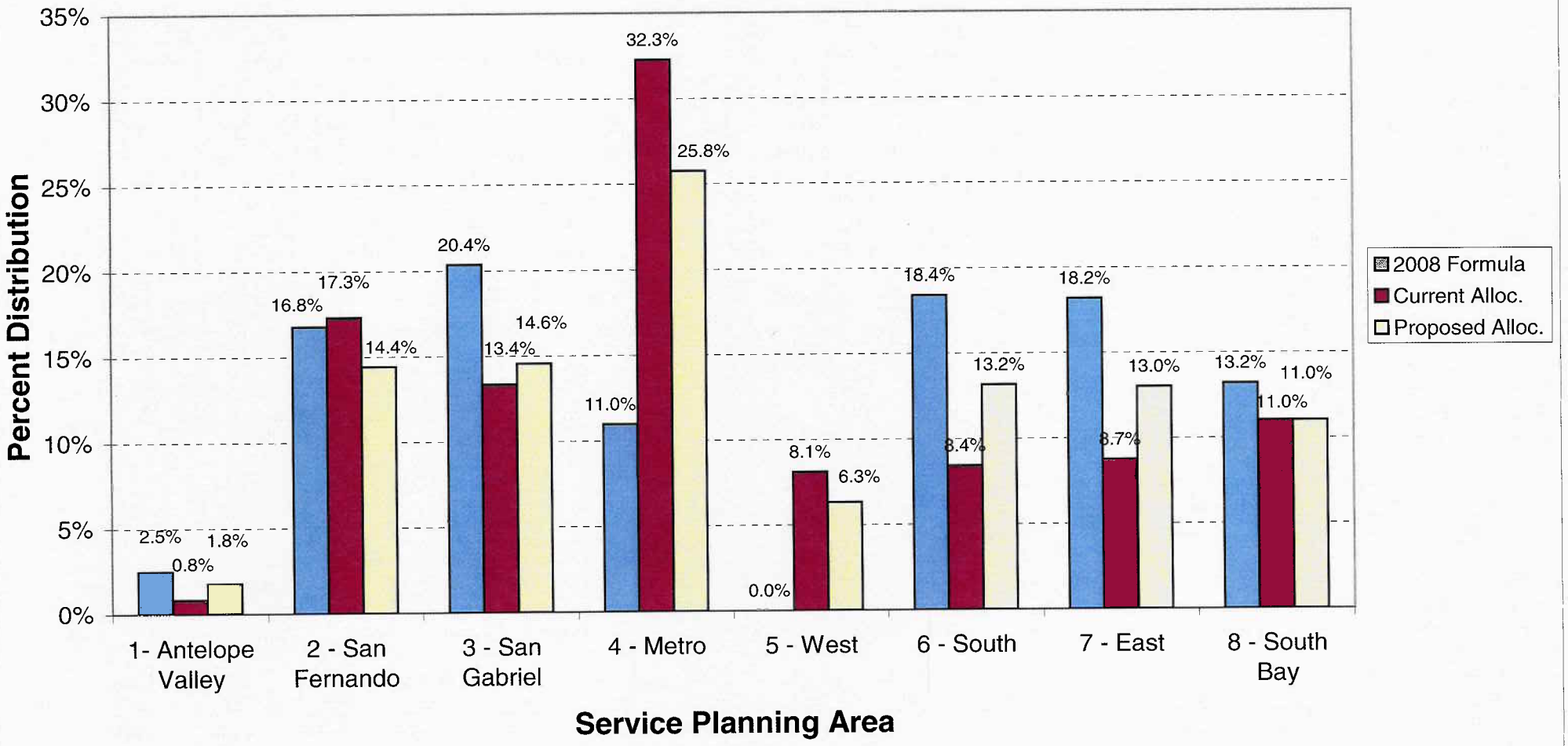
Los Angeles County
Designated and Pending Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs)



LAC DHS Office of Planning and Analysis
January 20, 2009

Current PPP Allocation (FY 08/09) Compared to 2008 Updated Needs Formula and Proposed Allocation (Current + New Funds)

DRAFT



LAC DHS Planning and Analysis, 1/20/09

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

January 29, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

PROGRESS REPORT - TRANSFER OF ALCOHOL AND DRUG PROGRAM ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

On October 7, 2008, your Board approved a motion by Supervisor Antonovich instructing the Chief Executive Office to develop recommendations to the Board within 30 days regarding the transfer of Alcohol and Drug Program Administration from the Department of Public Health to the Department of Mental Health. On October 24, 2008, we advised your Board that given the significance of the matter, additional time would be required to conduct a meaningful analysis and we anticipated providing a written progress report and a final report by March 2009. This memo represents our progress report.

This office has convened a working group of key departmental staff to coordinate the various elements of our review. We have compiled and are assessing background material applicable to this study, including a previous Grand Jury recommendation on this matter. We are also examining programs currently integrated within the two departments. In addition, we have sought and are evaluating opinions about potential issues, the pros and cons of such a transfer, and have identified additional steps necessary to proceed with and conclude the assessment.

We are also soliciting input from the various stakeholders who partner with the impacted departments. The resulting information will be utilized to finalize the assessment and formulate our final report and recommendations concerning this issue, which is still targeted for March 2009.

If you have any questions or need additional information, please contact me, or your staff may contact Richard Martinez at (213) 974-1758 or rmartinez@ceo.lacounty.gov or David Seidenfeld at (213) 974-1457 or dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
MLM:JS:yb

c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Mental Health
Director and Health Officer, Department of Public Health
Mental Health Commission
Public Health Commission
Commission on Alcoholism
Narcotics and Dangerous Drugs Commission

012909_HMHS_MBS_ADPA Transfer

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WILLIAM T FUJIOKA
Chief Executive Officer

REVISED
AGENDA ITEM #12

December 16, 2008

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angles, CA 90012

Dear Supervisors:

STATE BUDGET REDUCTIONS, DEFERRALS, AND TARGET HIRING FREEZE SAVINGS - FISCAL YEAR 2008-09 (ALL DISTRICTS AFFECTED) (3-VOTES)

SUBJECT

Board approval is recommended for budget adjustments to realign the County budget with State budget reductions and transfer funding from various budget units to supplement funding set aside as an economic reserve.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve the attached appropriation adjustment (Attachment I) that transfers $17,932,000 in net County cost from the Provisional Financing Uses budget unit to various County departments to provide bridge funding related to State budget reductions.

2. Approve the attached appropriation adjustment (Attachment II) that transfers $144,203,000 in net County cost from various budget units to the Provisional Financing Uses budget unit to be set aside to supplement the County's economic reserve.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On October 7, 2008, we reported to your Board as part of the 2008-09 Supplemental Budget recommendations, that due to worsening economic conditions and budget uncertainties at both the State and federal levels, we would return to your Board with recommendations on the following:

- Implement initial actions to align the County budget with the State adopted budget;
- Defer or eliminate funding provided during the 2008-09 Proposed and Final Changes Budget phase; and
- Develop recommendations regarding Countywide hiring freeze targets.

State Budget Impacts

Our office, in consultation with County departments, reviewed the adopted State budget cuts and analyzed their impact on County administered programs and the County Budget. Given the sharply deteriorating economic conditions facing the County, the extremely negative near-term economic outlook, the prospect of additional State budget actions, and the County's Budget Policy [4.030(5)] not to backfill State and federal programs, we are recommending that the County provide funding to backfill only two State budget actions for the remainder of the fiscal year, both related to inpatient psychiatric care.

Overall, the impact of the State adopted budget creates a $113.8 million shortfall. The majority of the shortfall has been already addressed in the County's adopted budget. The action requested today is to realign the remaining County programs impacted by the State budget, which totals $17.9 million.

We recommend that your Board provide a total of $11.6 million in one-time funding for mental health programs to continue to keep 224 inpatient psychiatric beds open. The first recommendation provides $6.3 million for ancillary services for Institutions for Mental Diseases (IMD) beds to preserve 192 beds. The second is $5.2 million to cover a cost increase for State hospital beds that would require the Department of Mental Health to shut down 32 inpatient psychiatric care beds. Funding for these services has

enabled the Department of Mental Health (DMH) to relieve the long-standing problem of overcrowding of mental health patients in County hospitals and County jails. We are recommending the use of one-time funding for this fiscal year until these reductions can be considered along with other reductions the County may be facing in Fiscal Year 2009-10. Our office and DMH are examining expanding capacity by using Mental Health Services Act (MHSA) funding for IMD Step Down facilities. However, developing these sites is a lengthy process and cannot be implemented immediately. Currently, IMD step-down programs funded with MHSA dollars are full.

Due to delays in adopting the State budget, the County plans to implement most of the State budget impacts effective January 1, 2009, except as noted above. In addition to the $11.6 million noted above, we are recommending that an additional $6.3 million in one-time net County cost be transferred from the Provisional Financing Uses budget to County departments impacted by the State budget cuts. This transfer will provide six (6) months of funding and allow for an orderly process to implement the program reductions. Attachment III is a listing of the recommended amounts to be transferred along with other adjustments to the budget for State budget action.

A more detailed description of how State budget actions impact the County appears in the Impact to Current Services section of this letter.

Given that the State is now facing an $11.2 billion current year shortfall and a $27.8 billion shortfall next year, we may return to your Board at a later date with additional recommendations to further realign the County Budget with State budget actions as a result of subsequent actions the State may take. As a consequence of this, coupled with the grim economic outlook we face, the County should continue to build on our early successes of new initiatives and efficiencies while eliminating unnecessary spending. The actions recommended in this report are a first step to addressing what will be a more significant budgetary shortfall in the future.

Review of New or Expanded Programs

Our office, in consultation with County departments, reviewed new or expanded programs that received additional funding during the 2008-09 Proposed and Final Changes Budget phases to determine if the program funding could be deferred or eliminated. We also reviewed funding earmarked for capital programs. We are recommending that $144.2 million be transferred to the Provisional Financing Uses budget as outlined in Attachment IV. This amount would be used to supplement $80.5 million already set aside as an economic reserve, bolstering the economic reserve amount to $224.7 million. This reserve is critical to the County's ability to address the economic situation the County is facing.

We are recommending that $2.5 million in funding be transferred from the Department of Parks and Recreation's ($1.0 million) and the Auditor-Controller's ($1.5 million) operating budgets. This includes $1.0 million in funding for Parks and Recreation's staff and operations associated with new and refurbished park facilities that were scheduled to open in the current fiscal year but will be deferred due to construction delays. In addition, $1.5 million in funding provided to the Auditor-Controller for a feasibility study for a new integrated property tax system could be deferred since funding for the overall new integrated property tax system is unlikely in the current economic environment. We will work with the Auditor-Controller to explore alternative funding sources for the project including the Information Technology Infrastructure Fund.

We are also recommending that $141.7 million from various capital project budgets also be transferred to the Provisional Financing Uses budget. The largest recommended transfer would come from the Hall of Administration Replacement budget in the amount of $84.8 million. This recommended transfer would leave $80.0 million, which would be an amount sufficient to get the project moving forward in combination with debt financing. For the Hall of Justice, Coroner, and Patriotic Hall refurbishments, we recommend that $7.0 million remain in each capital project budget with the balance of the project being funded through long-term financing. The Sheriff's Department projects and the remainder of Health Services projects are being placed in the Provisional Financing Uses budget pending future consideration of capital priorities of the departments.

Countywide Structured Hiring Freeze Targets

It is widely accepted that the current economic environment is likely to deteriorate further, causing additional erosion to the County's general purpose revenues. In anticipation of this, our office worked with County departments to develop targeted savings goals for the current year. These savings goals could serve as the basis for future year's budget reductions that may be necessary. Working with the departments, we were able to identify $33.1 million in savings from County departments. This is in-lieu of a hard hiring freeze and will allow departments the flexibility to determine how best to meet their target. This is likely the first step in many to reduce the size of the County budget given the dire economic crisis the nation is facing.

The savings goals avoid service curtailments and do not impact high-priority programs. These savings goals will be achieved through a variety of measures including departmental hiring freezes, reduction in purchases of services and supplies and fixed assets, and the generation of additional revenues. Attachment V identifies the savings goal target by department. Some departments were unable to identify a savings target

due to significant reductions in State revenues already taken. However, our office will continue to work with them to focus on efficiencies wherever possible.

Looking Forward - Future Board Reports

As noted in our supplemental budget request, we plan to return to your Board on January 27, 2009 to provide you information on the following items:

- Updated multi-year fiscal forecast including property tax and general purpose revenue projections;
- Budget Status Report;
- Report on the October 7, 2008 Board order pertaining to Fiscal Stability that directs our office to establish financial targets, set and meet cost reduction goals, and identify and eliminate areas of duplication while looking for opportunities to consolidate key functions and responsibilities; and
- Report on the October 7, 2008 Board order regarding establishing a County "Rainy-Day Fund", which could serve to protect County assets by systematically setting aside funds during good times and accessing them during times of need.

FISCAL IMPACT/FINANCING

Earlier this year, our office reported that the impact of State budget actions on the County was estimated to be $128.6 million. We now estimate the total impact to be ~~$137.6~~ $113.8 million. Since some of the State budget impacts were either already incorporated into the County budget, absorbed by departments, or departments were able to realign their budget to accommodate the State changes, we recommend that $17.9 million be transferred from the Provisional Financing Uses budget. The recommended adjustments have no overall net County cost impact since they are financed with the transfer of existing funding from one budget unit to another.

We are also recommending the transfer of $144.2 million of existing funding to supplement the economic reserve in the Provisional Financing Uses budget.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The recommended action is consistent with the County Strategic Plan Goal of Fiscal Responsibility by not extending the County's fiscal capacity beyond available financing sources.

IMPACT ON CURRENT SERVICES

Reduction in State funding will have the following impacts.

Children and Families' Well-Being

The adopted State budget reduced the Department of Community and Senior Services (CSS) funding by $4.3 million with cuts in Adult Protective Services ($2.6M), Title V (employment program for seniors - $0.9 million), Ombudsman Program (advocacy of residents in long-term care - $0.6 million), Supportive Services for seniors to prevent institutionalization ($0.2 million), and the Disease and Health Promotion Program (programs that increase quality of seniors' lives - $0.2 million).

While the impact to Adult Protective Services was significant, CSS was able to draw down additional federal funds to mitigate the impact of the State's cut. The primary impact of the cuts affected the services provided to seniors. For Title V, about 100,000 hours of paid job training had to be cut; the Ombudsman contractor had to lay off 17 employees, reducing the ability to follow-up on complaints related to nursing home care; the cut to Supportive Services will minimally reduce the number of seniors that can be provided the services (homemaker chore, light housekeeping, transportation, etc.) that are needed to enable seniors to remain in their homes as long as possible; and the cut to the Health Promotion Program will eliminate providers' "Be Well Program" which assessed and tracked seniors' health/well-being.

The State's Budget also reduced funding for CalWORKs, In Home Supportive Services, and Medi-Cal Administration. These reductions significantly impacted the Department of Public Social Services (DPSS), and required that the Department, in collaboration with our office and the Board of Supervisors' offices, identify curtailments in DPSS services and administration costs. The primary objective of this effort was to preserve the most critical services, while avoiding layoffs and demotions. As a result, a hiring freeze was imposed, at a time when caseloads are increasing due to the current economic conditions and rising unemployment rate.

The curtailments have resulted in increased workloads for employees and increased wait times for the public. The Department also reduced the eligibility period for transportation and ancillary costs for some welfare-to-work participants, and reallocated unspent funding, including unspent homeless and housing funds, to backfill a portion of the funding reduced in the State Budget. In addition, DPSS postponed and/or suspended vital Information Technology and Customer Service Center projects. These projects will be reconsidered at a future date.

Public Safety

The adopted State budget resulted in a loss of public safety funding of $1.4 million (including 1.0 positions) for the Sheriff; $0.4 million (including 2.5 positions) for the District Attorney, and $11.3 million (including 126.0 positions) for the Probation Department. Programs impacted include Juvenile Camps, Community Oriented Policing Services (COPS), California Multi-jurisdictional Methamphetamine Enforcement Teams, Mentally Ill Offender Crime Reduction, Hardcore Gang Prosecution, Abolish Chronic Truancy, and Community-Based Substance Abuse Treatment Programs (Proposition 36). These reductions adversely impact ongoing efforts to reduce juvenile crime and ensure successful reintegration of youthful offenders back into the community, efforts to provide mental health treatment to individuals in the justice system, and efforts to fight crimes associated with gang violence and the manufacture of illegal drugs.

The shift of existing funding to backfill State reductions will result in reductions in other program areas. However, this may be necessary as departments complete the review of current operations in an effort to continue to provide the most critically needed services. In addition, departments continue to seek new funding sources.

Health and Mental Health Services

Department of Health Services

The 2008-09 State budget cut to the Department of Health Services (DHS) was $13.9 million. Medi-Cal rates were reduced by $8.6 million and $5.3 million in California Healthcare for Indigents Program (CHIP) was eliminated. The noted revenue loss impacts a portion of DHS' overall program costs and not a specific patient service. At this time, DHS will utilize one-time funds to backfill the loss of revenue.

It is important to note that although DHS did not reduce services this fiscal year, a reduction of $13.9 million equates to the loss of approximately 34,000 non-hospital based outpatient visits per year. Additionally, the State's action has increased DHS' deficit, which is currently projected at $360.5 million for fiscal year 2009-10.

Department of Mental Health

The State budget cut to the Department of Mental Health (DMH) was approximately $14.4 million, and the reduction impacts the Mental Health Managed Care Program ($2.9 million), ancillary services provided to patients in Institutions for Mental Disease (IMD) beds ($6.3 million), and the cost of State Hospital beds ($5.2 million). As noted above, we are recommending that the County backfill the cost increases associated with ancillary services provided to patients in Institutions for Mental Disease (IMD) beds and the State Hospital beds in order to keep 224 inpatient psychiatric beds open.

The loss of funding from the Mental Health Managed Care Program will decrease and ration services to the uninsured and undocumented clients that need mental health services. The reduction of funding will be shared by directly operated programs and contract providers. Discontinuing mental health services to unfunded clients could result in increases in admissions to psychiatric emergency rooms and inpatient facilities. It is possible that increases in arrests and incarcerations could result as individuals who require mental health assistance may go untreated.

Department of Mental Health and its stakeholders are currently reviewing mitigation strategies for this curtailment, including looking at opportunities for transformation of services under the Mental Health Services Act (MHSA). These curtailments and/or transformations will be effective July 1, 2008.

Department of Public Health

The State budget cut to the Department of Public Health (DPH) was approximately $20.4 million and reduces approximately 146.5 budgeted positions. The reduction primarily impacts the California Children's Services (CCS) ($9.1 million and 143.0 budgeted positions), the Substance Abuse and Crime Prevention Act (Prop. 36) and Offender Treatment Programs (OTP) ($8.9 million), programs within Alcohol and Drug Program Administration (ADPA) ($1.5 million), the Office of AIDS Programs and Policy (OAPP) ($0.7 million) and Public Health Programs (PHP) ($0.2 million and 3.5 budgeted positions).

For the CCS program, DPH estimates a 45 percent reduction in the number of medical authorizations completed on a monthly basis (11,000 fewer), eligibility determination waiting periods increasing from 5 to 15 days, the elimination of 40 outreach events serving approximately 3,000 children, and the elimination of pediatric and palliative care for as many as 2,000 children in the County.

Of approximately 143.0 budgeted positions, 55.0 are currently filled and our office is recommending funding for DPH to develop and implement a staffing mitigation plan to avoid layoffs.

Based on the State funding reductions for Prop 36 and OTP, DPH estimates a loss of approximately 20,000 inpatient bed days, 265 outpatient slots/visits, and 4,000 substance abuse assessments. In order to align contracted service levels with the revised available funding resources, DPH will implement contract reductions targeted to be effective in mid-January.

Based on the State funding reductions for Drug Court, Perinatal and State General Fund Programs, DPH estimates a loss of approximately 1,400 inpatient bed days and 29 outpatient slots/visits. In order to align contracted service levels with the revised available funding resources, DPH will implement contract reductions targeted to be effective in mid-January.

Though DPH anticipates being able to mitigate a majority of the State funding reductions to OAPP with available and unobligated grant resources, DPH will not be able to mitigate the funding reduction to their allocation for counseling and testing and, as a result, estimates a reduction of approximately 1,000 HIV/AIDS tests to be conducted/available. Such reduction will inevitably result in a delay of the provision of HIV/AIDS treatment services. In the event DPH is unsuccessful in mitigating the funding reductions to their treatment, education, and prevention allocations, fewer individuals and their conditions will be treated and/or delays in treatment will arise. Furthermore, OAPP's education and prevention efforts throughout the County will be impacted. In order to align the contracted number of HIV/AIDS tests being conducted in the County with the revised available funding resources, DPH will implement contract reductions targeted to be effective in mid-January.

Although DPH anticipates being able to mitigate the State funding reductions for both TB and maternal, child, and adolescent health services, should DPH be unsuccessful, the potential result could be a delay in the identification and analysis of reported TB cases/suspects in the County and a decrease in the amount of services provided to infants, mothers, and families through the MCAH program.

Community and Municipal Services

The adopted State budget reduced funding from the State Public Library Fund (PLF) by $0.2 million, which is used to augment Public Library's base budget for books and materials (B&M). The B&M budget funds the purchase of books, periodicals, audiovisual formats, electronic database subscriptions, and other items for circulation to the public at 85 libraries and four bookmobiles throughout the County. Funding also supports the purchase of materials for various programming activities such as textbooks and curriculum support materials used in homework centers, workbooks and reading materials used in literacy centers, and a variety of materials used in programs for children, teens and adults. The funding reduction will reduce the amounts allocated to these programs and will impact all library facilities in the County.

Respectfully submitted,

WILLIAM T FUJIOKA
Chief Executive Officer

WTF:SRH:DIL
SK:MM:yjf

Attachments

c: Department Heads

Los Angeles County
Department of Regional Planning

Planning for the Challenges Ahead

Jon Sanabria
Acting Director of Planning

April 8, 2009

TO: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

FROM: Jon Sanabria
Acting Director of Planning

SUBJECT: Response to Board Motion Regarding Mitigation Monitoring Program (October 7, 2008, Item #94-F)

The following is the Department of Regional Planning's (DRP) response to Supervisor Zev Yaroslavsky's motion of October 7, 2008, directing that we report back to the Board regarding 1) the adequacy of DRP's existing mitigation monitoring program compliance checks 2) the amount of available funding the Department has dedicated to this effort, the amount the Department has been collecting and expending over the past two years, and the amount it expects to collect in the future, 3) staffing plan and 4) recommend mechanisms for ensuring the fees are consistently collected and inspections are performed as required in mitigation monitoring.

Adequacy of Existing Mitigation Monitoring Program

The Impact Analysis Section of the Department of Regional Planning is confronted with increased workload requirements pursuant to Section 21081.6 of the State Public Resources Code. A number of significant projects have been approved with Mitigation Monitoring Programs since this law became a requirement in 1991. As these projects enter the development phase, the Department of Regional Planning is required to actively review, monitor and take appropriate action with respect to the adopted programs. Failure to administer these programs results in violation of State mandates.

In the past, mitigation monitoring has been divided among Impact Analysis staff in addition to other duties. This has proven ineffective in that staff has not been able to devote the necessary time to monitoring the mitigation measures. As a result, some approved projects have been found not in compliance with the Mitigation Monitoring Program requirements. This non-compliance with mitigation measures has caused an increase in the number of investigations conducted by the Department's Zoning Enforcement Section.

The Department does not currently have sufficient staff to successfully carry-out the goals of the program by continuously monitoring the Board of Supervisors and Regional Planning Commission's approved mitigation measures. The addition of dedicated staff would allow for implementation of the Mitigation Monitoring Program.

This would achieve the desired increase in project oversight. Revenue generated from continuous monitoring would fully offset this position for seven years. Implementing the aforementioned programs at this time may avoid future potential costs associated with possible legal action against the County.

Funding For Mitigation Monitoring Program

The balance for the EIR mitigation monitoring account was $386,235.00 as of April 2, 2009. The amount of money collected over the past two fiscal years included $63,537.64 during FY06-07 and $52,319.99 during FY07-08. The amount expended was $8,390.29 during FY06-07 and $6,887.79 during FY07-08. The Department anticipates collecting at least $40,000 to $45,000 per year in the future for mitigation monitoring. As long as the need for mitigation monitoring exists there will be adequate funding to offset the costs.

Staffing Plan, Fee Collection and Required Inspection

The Department is proposing the addition of one Regional Planning Assistant II position to ensure that the mitigation monitoring function is adequately and consistently performed. The technically sophisticated standards and criteria that are often associated with various mitigation monitoring measures sometimes may require additional review by a biologist. The RPA II can be supported by a contract biologist who is currently serving the Department on an as-needed basis.

The Impact Analysis Section in conjunction with the Budget and Accounting Services Section will monitor the employee's timesheets to ensure all work on mitigation monitoring is properly coded and billed. In addition, the Accounting Services Section will provide management with monthly mitigation monitoring account balances and send out supplemental deposit letters to applicants when needed. The Impact Analysis Section will ensure that its staff performs inspections as required in mitigation monitoring programs. All costs for this position will be revenue offset.

If you have any questions regarding this matter, please contact Paul McCarthy of the Impact Analysis Section at (213) 974-6461. Our offices are closed on Fridays.

JS:SA:lm

C: Chief Executive Office
Executive Officer, Board of Supervisors

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

October 24, 2008

To: Supervisor Yvonne B. Burke, Chair
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

REPORT ON TRANSFER OF ALCOHOL AND DRUG PROGRAMS ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

On October 7, 2008, your Board approved a motion by Supervisor Michael D. Antonovich instructing the Chief Executive Office to develop recommendations to the Board within 30 days regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH).

Given the significance and potential consequences of the proposed transfer, we are requesting additional time to complete the comprehensive review we have initiated to date. We are researching the background of ADPA's current placement within DPH and the program responsibilities of both ADPA and DMH, studying the merits of comparable organizational models from other counties, and developing information about the feasibility, benefits, and consequences of transferring ADPA to DMH. In addition, both DPH and DMH have client and provider constituencies, including their respective advisory Commissions, which we will involve in our review through the departments' respective stakeholder processes.

In addition to stakeholder input, we will also review studies that were previously conducted regarding this proposed transfer such as the report prepared by the Los Angeles County Civil Grand Jury. As part of an analysis of implementing a health authority for the County's health and hospital system, the 2004-05 Grand Jury recommended that the County consider placing the ADPA function under DMH and creating a Behavioral Health Department. However, on May 30, 2006, the Board approved the creation of DPH, including the continued placement of ADPA within DPH.

Accordingly, we anticipate providing your Board with a written progress report by mid-December 2008 and a final report by March 2009. This time frame will allow us to conduct a meaningful analysis, make sound recommendations and, should a transfer be recommended, prepare for any necessary personnel changes or adjustments to the departments' annual budgets.

If you have any questions or need additional information, please contact me, or your staff may contact Richard Martinez at (213) 974-1758 or rmartinez@ceo.lacounty.gov or David Seidenfeld at (213) 974-1457 or dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
MLM:JS:yb

c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Mental Health
Director and Health Officer, Department of Public Health
Mental Health Commission
Public Health Commission
Commission on Alcoholism
Narcotics and Dangerous Drugs Commission

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
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WILLIAM T FUJIOKA
Chief Executive Officer

July 1, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

PROGRESS REPORT - TRANSFER OF ALCOHOL AND DRUG PROGRAM ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

On October 7, 2008, your Board approved a motion by Supervisor Antonovich instructing the Chief Executive Office (CEO) to develop recommendations to the Board within 30 days regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH). On October 24, 2008, we advised your Board that given the significance of the matter, additional time would be required to conduct a meaningful analysis and we anticipated providing a written progress report and a final report.

This represents our progress report to your Board relative to this effort. A working group of CEO and departmental staff has been convened and held several meetings to coordinate the various elements of our review. We have compiled and initiated our assessment of background material applicable to this study, including a 2004-05 Grand Jury recommendation on this matter, and examined programs currently integrated within the two departments. In addition, we have sought and are evaluating opinions about potential issues, the pros and cons of such a transfer, and have identified additional steps necessary to proceed with and conclude the assessment.

In general, input from substance abuse advocates recommend keeping substance abuse agencies separate from mental health agencies; and mental health input reflected the benefits of integrated programs and of providing services to address co-occurring disorders. During this Office's review of the pros and cons of such a transfer, we will identify the specific issues raised by both the proponents and opponents of the transfer to develop recommendations which address the need to improve the

coordination of care provided to clients and make optimal use of both mental health and substance abuse services. Furthermore, upon completing our meetings with the various stakeholders and obtaining their input, this Office will assess the concept of transferring ADPA to DMH against the following criteria: policy and program benefits and implications; fiscal and administrative benefits/implications to DPH, DMH, and the County overall; and service delivery benefits/implications to the service populations of DPH and DMH.

To date we have received a breadth of information from both DPH and DMH, including documentation from the California Association of Alcohol and Drug Program Executives, Inc. (CAADPE). As a non-profit professional association of alcohol and other drug abuse agencies, CAADPE's mission is to educate the public about the need for quality alcohol and other drug abuse services to meet community needs and to actively participate in public dialogue about alcohol and drug services. Additionally, at the request of CAADPE, we met with several of their members to discuss this proposal.

Based on the information that has been obtained thus far, we have prepared the attached interim report and it will be submitted to both DPH and DMH advisory Commissions. We are scheduled to meet with the Commissions, on the following dates, to seek their input, as well as DMH's and ADPA's client and provider constituencies, regarding the placement of ADPA:

- Commission on Alcoholism, Wednesday, July 8, 2009;
- Narcotics and Dangerous Drugs Commission, Wednesday, July 15, 2009; and
- Mental Health Commission, Thursday, July 23, 2009.

The resulting information will be reviewed to finalize the assessment and formulate our final report and recommendations concerning this issue, which is targeted for August 7, 2009.

If you have any questions or need additional information, please contact me, or your staff may contact Richard Martinez at (213) 974-1758 or rmartinez@ceo.lacounty.gov or David Seidenfeld at (213) 974-1457 or dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
MLM:TOF:bjs
Attachment
c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Mental Health
Director and Health Officer, Department of Public Health
Mental Health Commission
Commission on Alcoholism
Narcotics and Dangerous Drugs Commission
Public Health Commission

PLACEMENT OF

THE LOS ANGELES COUNTY

ALCOHOL AND DRUG PROGRAM ADMINISTRATION

INTERIM REPORT

Chief Executive Office
July 2009

PLACEMENT OF THE LOS ANGELES COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATION

TABLE OF CONTENTS

- (1) Input is pending.
- (2) Input has been received.

PLACEMENT OF THE LOS ANGELES COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATION

1.0 OVERVIEW

On October 7, 2008, the Board of Supervisors (Board) instructed the Chief Executive Office (CEO) to develop recommendations regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH).

The concept of consolidating substance abuse and mental health services into a single agency raises several concerns and numerous agencies have previously conducted studies. To provide the Board with a comprehensive report a three phased process is being pursued.

The first phase included research of the issue, compilation of information from within and outside the County, and preparation of the Placement of the Los Angeles County Alcohol and Drug Program Interim Report (Interim Report). During the second phase, the Interim Report will be transmitted to DMH and ADPA Advisory Commissions, as well as other key stakeholders, to obtain their input regarding the proposed placement of ADPA. Once stakeholder input has been obtained, the third phase will consist of a final report to the Board, targeted for August 7, 2009. The final report will include assessment and formulation of recommendations to the Board. DMH and DPH will be provided an opportunity to comment on the report before it is finalized.

To guide and coordinate the study, a work group was convened which consisted of representatives from the CEO, DMH, and DPH.

2.0 COUNTY DEPARTMENT INPUT

As key participants and members of the work group, both DMH and DPH provided Issue Papers that identified (from their perspective), concerns, advantages, disadvantages, and other relevant information regarding the placement of ADPA.

2.1 Department of Mental Health – Issue Paper / Exhibit A

Outlines the advantages and disadvantages regarding the integration of substance abuse and mental health treatment from clinical and programmatic perspectives.

From the clinical perspective, the DMH paper conveys that the most convincing reason for such integration is the overlap in treatment populations, and that the integrated treatment for both problems in the same location by the same clinicians can result in better treatment outcomes. Clinical disadvantages include the likely separation of substance abuse treatment form general medical treatments, and the

stigmatization that integrated treatment may have on outreach and treatment of substance abuse clients. Programmatic benefits include improved coordination of different treatments and improved communication among clinical and administrative staff. A key programmatic disadvantage is that significant difference in programs structures, regulatory oversight, licensing and compliance requirements.

2.2 Department of Public Health – Issue Paper / Exhibit B

Outlines the program and policy, financial, administrative, and service delivery implications related to the concept of consolidating substance abuse and mental health services into a single agency.

The DPH issue paper outlines that there is a low likelihood for significant program integration due to underlying distinctions in the fields of substance abuse and mental health, that the placement of ADPA within DMH would diminish the integration with other public health programs (i.e. Tobacco Control, sexually transmitted disease (STD), tuberculosis (TB), and human immunodeficiency virus (HIV) Programs) focused on prevention, that no significant cost savings would be achieved with the transfer of ADPA as mental health and substance abuse funding streams differ and would still require differing program conditions and requirements, and that improved program integration could be achieved via a Memorandum of Understanding (MOU) between the two departments.

3.0 ADDITIONAL INFORMATION

The work group conducted research to obtain background information that could assist with the analysis of the placement of ADPA. It should be noted that at this point in time, the information is provided as reference and to serve as a discussion starting point. The review, analysis, options, and recommendations as to the placement of ADPA will be provided once stakeholder input, a key component of this effort, is obtained. The following information was identified as pertinent to this effort:

- Identification of programs that are currently funded as a joint effort on the part of DMH and DPH;
- 2004-05 Grand Jury Report that discussed the placement of ADPA;
- Survey of surrounding California counties identifying the placement of their ADPA operation; and
- 2004 California Report that discussed the placement of ADPA.

3.1 Jointly Funded Programs / Exhibit C

A total of 14 programs were identified in which DMH and DPH are currently collaborating in providing services to County residents. Nine programs involve $1.1 million in funding that is provided to DMH and involve services such as diagnostic services and training. Five programs involve $.5 million in funding that is provided by DMH and involve assessment, residential, and counseling services.

3.2 2004-05 Grand Jury / Exhibit D

Excerpts from the 2004-05 Grand Jury Report that discussed the creation of a Los Angeles County health authority and which County departments should be transferred to the health authority. The report incorporates analysis of related issues and implications, and the definition of the health authority's mission and functional components, including a recommendation as to the placement of ADPA.

3.3 Placement of ADP – State of California and Surrounding Counties / Exhibit E

The CEO conducted a survey of the State of California and five surrounding counties to identify the organizational structure and mission as it pertains to the health, public health, and mental/behavioral health services provided by these agencies. The State of California has a separate Department of Mental Health and a Department of Alcohol and Drug Programs. Surrounding counties surveyed; include:

- Orange County – Substance abuse and adult mental health services are organized under the Behavioral Health Services Section of the county's Health Care Agency;
- San Bernardino County – Substance abuse services are organized under the county's Department of Behavioral Health;
- Riverside County – Substance abuse and adult mental health services are organized under the county's Department of Mental Health;
- San Diego County – Substance abuse services and mental health services are organized under the Behavioral Health Section of the County's Health and Human services Agency; and
- Ventura County – Substance abuse and mental health services are organized under the Behavioral Health Section of the county's Health Care Agency.

3.4 2004 California Performance Review / Exhibit F

In 2004 the California Performance Review (CPR) issued a recommendation proposing the consolidation of the State Mental Health and Alcohol and Drug Programs. The proposal was never implemented and Exhibit F provides a summary of the CPR report. Although the matter

addressed the consolidation of Mental Health and ADP at the State level, the material provides a good summary on this important issue.

It should be noted that Exhibit G - California Association of Alcohol and Drug Program Executives (CAADPE), provides an analysis of the CPR recommendation.

Many of the findings, for and against, on the two exhibits noted above are on point as ultimately they address the proposed consolidation of the same programs.

4.0 STAKEHOLDER INPUT

A major component of any study is the input provided by its stakeholders. The Mental Health Commission, Commission on Alcoholism, and Narcotics and Dangerous Drugs Commission (Commissions), and their respective constituencies have been identified as key stakeholders. Meetings have been scheduled to solicit and obtain their valuable input on the noted dates.

The Commissions are encouraged to engage their constituencies to participate in the stakeholder process and a copy of the Interim Report will be provided, in advance of the scheduled meetings, and is intended to be used a starting point to encourage dialogue. The Commissions' Minutes will be requested and written input may also be provided, a one-week deadline will be established following each Commission meeting.

4.1 Mental Health Commission – Pending

4.1.1 Meeting scheduled for Thursday, July 23, 2009, – 500 West Temple Street, Room 739, Los Angeles, CA 90012

4.1.2 Commission Minutes and other written input may be submitted to the CEO by Thursday, July 30, 2009.

4.2 Commission on Alcoholism – Pending

4.2.1 Meeting scheduled for Wednesday, July 8, 2009, 1000 South Fremont Ave, Bldg A-9 East. Alhambra, CA 91803, Conference Room G-2

4.2.2 Commission Minutes and other written input may be submitted to the CEO by Wednesday, July 15, 2009.

4.3 Narcotics and Dangerous Drugs Commission – Pending

4.3.1 Meeting scheduled for Wednesday, July 15, 2009, 500 West Temple, Room 320. Los Angeles, CA 90012.

4.3.2 Commission Minutes and other written input may be submitted to the CEO by Wednesday, July 22, 2009.

4.4 Other Stakeholders - Pending

In addition to the input provided by the noted County commissions, the input of other stakeholders is welcomed, as of this writing the following organization contacted our office to provide input on this issue.

4.4.1 California Association of Alcohol and Drug Program Executives (CAADPE) / Exhibit G

At the request of CAADPE, a non-profit association of alcohol and other drug abuse agencies, the CEO met with several of their members. The mission of CAADPE is to educate the public about the need for quality alcohol and other drug abuses services to meet community needs and to actively participate in public dialogue about alcohol and drug services.

CAADPE provided a cover letter and several attachments which are identified as Exhibit G of this Interim Report.

EXHIBIT A

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH

EXISTING ELEMENTS OF INTEGRATED APPROACHES TO MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

CLINICAL PROGRAMS

Jail Mental Health Service:

Four licensed and waivered chemical dependency counselors, employed by DMH, are placed within the Jail Mental Health Program. They provide assessment of co-occurring substance abuse and work with other clinical staff to develop an integrated treatment plan for inmates with both mental health and substance abuse problems.

Clinic-based COD programs:

The DMH Harbor/UCLA Outpatient Mental Health Center contains the Co-occurring Disorders Outpatient Services Program, consisting of integrated mental health and substance abuse staff. The program provides services to approximately thirty clients at any given time. These services address both MH and SA problems.

Hollywood, Arcadia, and Long Beach Mental Health Centers (MHCs) most extensively employ licensed substance abuse counselors in the context of mental health programs to provide integrated substance abuse treatment. Other MHCs provide substance abuse counselors for limited assessment, treatment, and consultation within the context of mental health treatment.

Community Assessment and Screening Centers (CASCs):

ADPA operated Community Assessment and Screening Centers (CASCs) provide substance abuse counselors in selected acute DMH treatment programs in order to rapidly screen and refer individuals with co-occurring SA problems to ADPA treatment programs. This provides an integrated assessment and the potential for subsequent integrated treatment as indicated. The sites are Harbor/UCLA Psychiatric Emergency Service, the Olive View Urgent Care Center (UCC), Westside UCC, and LAC+USC UCC.

MHSA programs:

Full Service Partnerships, Wellness Centers, and Client-run centers provide integrated SA services using MHSA funding specifically approved for these purposes. Licensed substance abuse counselors work within these programs to provide assessment, integrated treatment, and referral for more specialized services as necessary, including residential services.

Collaborative Service Programs:

DMH contracts with ADPA providers to operate a series of contiguous programs For example, South Bay MHC and BHS Pacifica House operate contiguously sited programs to deliver MH and SA services, with frequent consultation and joint case planning between the two staffs.

DMH funded MH services within ADPA programs:

DMH contracts with specific ADPA programs for the provision of mental health services within SA services, creating a continuum of treatment. Such contracts, e.g. with Tarzana Treatment Center and River Community, provide resources for licensed mental health clinicians to deliver onsite mental health services.

Informal Clinical Collaborations:

Multiple DMH directly operated and contracted MHCs have informal agreements as "sister facilities," facilitating ad hoc joint treatment planning for individuals with COD who are receiving services in both agencies.

DMH COD TRAINING

UCLA Integrated Substance Abuse Programs (ISAP)

DMH contracts with UCLA Integrated Substance Abuse Programs (ISAP) to provide comprehensive and ongoing training and consultation to mental health clinical staff on integrated substance abuse assessment and treatment, building competencies within DMH to work effectively in integrated treatment settings.

The COD Peer Advocate Program:

This twelve-year-old program provides comprehensive classroom and internship-based training for recovering COD consumers leading to employment in ADPA and DMH sites. Twenty individuals graduate yearly.

The UCLA Extension Integrated COD Certification Program:

ADPA/DMH sponsors this ten month program which provides specialized classroom training and networking for ADPA and MH staff in the delivery of integrated treatment, graduating thirty students per year. In its twelfth year this program provides a foundation of clinicians with enhanced competencies for development of integrated programming.

JOINT PROGRAM DEVELOPMENT AND REVIEW

Substance Abusing Mentally Ill Taskforce

The Substance Abusing Mentally Ill (SAMI) Taskforce was initiated nineteen years ago to provide a framework for joint programmatic development for ADPA and DMH agencies. This group functions as an incubation and coordination entity for a variety of programs and policy initiatives. Among the programs that it has developed are:

1. **The "Sidekicks" Mobile COD Assessment Team program**: This award-winning program was the prototype for the subsequent development of intensive case-managed programs, including Assertive Community Treatment programs and full service partnerships.
2. **The COD Peer Advocate Program:** (See above)
3. **The UCLA Extension Integrated COD Certification Program:** (See above)

Joint Training Programs:

The Statewide COD Conference is jointly sponsored by ADPA and DMH. In its seventh year, it is a pre-eminent two day conference attracting approximately 650 attendees, equally split between primarily SA and primarily MH clinical and administrative workers, to hear nationally known speakers in both fields with a focus on integrated services.

DMH Clinical COD Program Development:

DMH, with consultation from ADPA and others, has developed extensive COD assessment and treatment guidelines and assessment instruments. These are required for use with all DMH clients in order to identify and address substance abuse issues and address them within the context of mental health care and/or through collaboration with ADPA agencies. These guidelines and instruments include the 9-Point treatment planning module, the supplemental substance abuse assessment tool, and the DMH parameters for treatment of co-occurring substance abuse and for use of psychiatric medications for individuals with co-occurring substance abuse.

DMH/ADPA Joint Policy Development:

The DMH Director co-chairs the California Co-occurring Disorders Joint Action Counsel (COJAC), a statewide committee with state and local membership comprising administrators and state regulators for publicly funded substance abuse and mental health programs. This Counsel sets statewide guidelines for integrated substance abuse treatment, including development of screening tools and outcomes measures.

Community Meth Taskforce:

DMH is an active participant in the Community Meth Taskforce, which is led by ADPA and the Office of AIDS Programs and Policies. This taskforce provides interdepartmental coordination for policies and services to address methamphetamine abuse.

EXHIBIT B

LOS ANGELES COUNTY – DEPARTMENT OF PUBLIC HEALTH

Issues to Consider Regarding the Transfer of Alcohol and Drug Program Administration (ADPA) from the Department of Public Health to Department of Mental Health

April 9, 2009

On October 7, 2008, the Board of Supervisors instructed the Chief Executive Office to develop recommendations to the Board regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH).

This paper outlines the program, policy, financial and service issues related to the concept of consolidating substance abuse and mental health services into a single agency.

EXECUTIVE SUMMARY

The potential benefits of consolidating ADPA with DMH need to be weighed against the following:

1) The low likelihood of significant program integration due to underlying distinctions in the fields of substance abuse and mental health which have remained in instances where consolidations have occurred;

2) The loss of integration with other DPH programs;

3) Financial and administrative implications; and

4) The potential to achieve improved substance abuse and mental health program integration via Memorandum of Understanding(s) between DPH and DMH, with review by the CEO.

Overall, the benefits of consolidation are not apparent. Moreover, the consequences of consolidation may diminish the priority given to substance abuse, and likely not yield appreciable cost savings or efficiencies of scale and will likely have a marginal negative impact on DPH costs.

PROGRAM AND POLICY ISSUES

Both substance abuse and mental health services share the underlying goal of improving human potential and function. However, there are distinct differences in the content, scope and approach that each contributes to the accomplishment of this goal.

The variation in approach and scope reflect the underlying differences in the causes of the conditions and the solutions that are employed to address substance abuse and mental illness. These differences affect program design, personnel skills, and the scope and variety of treatment and recovery services available.

Many substance abuse treatment models have their origins in community recovery movements, involving rehabilitation with a supportive community of peers. Substance abuse treatment agencies often include staff with experience-based rather than formal training. In contrast, mental health agencies typically emphasize a professional tradition of formal training and credentialing in academic departments of psychiatry, psychology, and social work. These distinctive backgrounds have led to differences in treatment philosophies and training which have been documented as resulting in distrust of treatments by substance abuse and mental health providers[1].

Prevention

DMH focuses primarily on the provision of a spectrum of mental health treatment services to individuals in Los Angeles County. Although ADPA contracts for an array of substance abuse treatment services, its focus on population-level substance abuse prevention is equally important. Substance abuse prevention entails a number of elements including addressing individual and community risk factors. ADPA collaborates with other DPH programs and community partners in assuring the implementation of a robust prevention program. The Methamphetamine Workgroup (discussed below) is an example of its prevention work.

Prevention is a core function for DPH and substance abuse prevention is a core mission of ADPA. If ADPA were transferred, given DMH's size and the primacy of its treatment focus, it is unlikely that a focus on prevention would be given priority. This would result in the loss of the important opportunity to reduce demand for substance abuse treatment services. In a jurisdiction where substance abuse and mental health services have been merged, the larger mental health agency focused on mental health early intervention services; at the same time substance abuse prevention services diminish as a priority[2].

Staff Implications

Staffing costs would not necessarily decrease because substance abuse personnel and mental health personnel are not interchangeable, and the loss of substance abuse staff expertise may occur. Alcohol and other drug services providers are frequently certified counselors who bring life experience and sometimes a history of recovery to their work. In contrast, mental health services are principally comprised of licensed professionals with graduate degrees. This results in different salary structures, training and certification needs. In states where substance abuse and mental health agencies have been merged, key stakeholders and directors reported loss of key substance abuse staff, difficulty in staff recruitment and retention[3].

Many substance abuse treatment models have their origins in community recovery movements, involving rehabilitation with a supportive community of peers. Substance abuse treatment agencies often include staff with experience-based rather than formal training. In contrast mental health agencies have a professional tradition of formal training and credentialing in psychiatry, psychology, and social work. The resulting differences in treatment philosophies and training have been documented as resulting in distrust of treatments by substance abuse and mental health providers[4].

Linkage to Other Public Health Priorities

Substance abuse contributes to a constellation of risks requiring a comprehensive and coordinated approach to effectively reduce disease and injury morbidity and mortality. The need for coordination among related public health programs is critical. For example, transferring APDA would separate it from the Tobacco Control Program. Both programs focus on the prevention and control of addictive substances that result in significant morbidity and mortality.

In addition, the role of substance abuse in increased STD and HIV risk behaviors has resulted in cross-training and collaboration among DPH programs. Specifically, part of the Federal funds received from California Alcohol and Drug Programs Substance Abuse and Treatment Block Grant (SAPT) require that a minimum amount be targeted toward services for individuals affected by HIV and TB and need to include counseling and education on HIV and TB, risks of needle sharing, risks of transmission to sexual partners and infants, preventive steps to ensure that HIV transmission does not occur as well as referral for HIV and TB treatment

Another area is methamphetamine use which presents an unprecedented challenge to the health and welfare of Los Angeles County residents. The Methamphetamine Prevention and Treatment Plan, Methamphetamine Workgroup, and resulting programs and services rely on close collaboration between ADPA, the Office of AIDS Programs and Policy, the Sexually Transmitted Disease Control Program and representatives from community- based agencies and other County departments. The transfer of ADPA to DMH would diminish this comprehensive approach.

Surveillance and Assessment

Increasingly ADPA activities are linked to DPH surveillance and assessment functions to produce high-quality and comprehensive health data about both clients and the Los Angeles County population to understand demand for services, inform planning, and evaluate program and service effectiveness. ADPA also uses surveillance and assessment data to understand trends in substance use beliefs, risk behaviors, substance use, and service utilization to guide its program development and evaluate assessment of program and service effectiveness. These activities are facilitated and supported by DPH's Health Assessment and Epidemiology Program as well as extensive collaboration with university substance abuse center researchers.

These population-level surveillance and assessment activities are crucial to assure the best use of limited substance abuse funds. ADPA's location in DPH facilitates its linkage to the LA Health Survey and participation in public health surveillance activities. In addition, other DPH programs are able to utilize substance abuse-related data allowing them to plan for their populations in a more comprehensive manner. Although a transfer would not preclude ADPA from participating in the LA Health Survey, this process could become more complex with no appreciable benefit to DMH or APDA.

FISCAL AND ADMINISTRATIVE ISSUES

In addition to the significant programmatic differences discussed above, considerable fiscal and administrative issues must be examined when considering the benefit of transferring ADPA to DMH.

Implications to DPH Finances

The transfer of ADPA to DMH will impact the administrative and fiscal structure of DPH. ADPA currently supports $1.8 million of administrative cost to DPH. This would further impact DPH's administrative capacity which was recently supplemented with additional items in recognition of the comparative understaffing in these areas when compared to other organizations. The funds provide support for administrative services for personnel services, financial and contractual services, legal assistance and information technology services. Transfer of ADPA would result in a loss of funds that support shared administrative costs which will not be proportionately reducible such as certain finance and administrative functions performed at the DPH level. To the extent this occurs, other funding, including net County cost, may be required to backfill the loss of ADPA funds.

Additionally, because ADPA and DMH have few funding mechanisms in common, there would be a need to coordinate funding as occurs today, and combining the two agencies would not result in significant increased efficiencies in financial management. It is important to note that even in the area of co-occurring disorders, mental health and substance abuse funding streams differ. Consequently, DMH and ADPA would still need to comply with different program conditions and requirements regardless of a transfer and it would be necessary to implement the same coordination/integration work regardless of where ADPA was placed.

Contract Administration Savings May Be Highly Unlikely

Although ADPA and DMH contract with some of the same service providers, the savings that may be associated with merging contract administration are uncertain. It is estimated that ADPA and DMH have 43 contract agencies in common. This compares to the 206 contract agencies overall in the ADPA network.

However, there are distinct differences between the contract portfolios of the two agencies. Despite a shared need for clinical treatment contractors, DMH and ADPA contract for a different spectrum of services. Specifically, ADPA has a significant number of prevention and non-clinical treatment contracts that would be maintained and added to DMH's current contract portfolio if the transfer were implemented.

Management and monitoring of ADPA and DMH contracts would require dual expertise on the part of contract management staff. Two sets of personnel would be needed: one with expertise in mental health and the other in substance abuse. ADPA and DMH have different types of contracts, stemming from different state/federal funding sources, each with specific programmatic, monitoring and reporting requirements. It is highly unlikely that any economies of scale would be gained combining these two vastly different contract portfolios.

SERVICE DELIVERY ISSUES

ADPA and DMH serve distinct and, at times, overlapping populations. Based on national estimates, less than 9% of the general population has been treated for both mental health and substance use disorders[5]. Research indicates that estimates of those in treatment with co-occurring disorders vary depending on the methods of measurement used[6]. However actual data from clients treated for substance abuse at Antelope Valley Rehabilitation Center in FY 2007-08 indicated that 15% had taken prescribed medication for mental health needs in the past 30 days[7]. In this case, the remaining 85% of patients required substance abuse services.

In considering the benefits of transferring ADPA to DMH it must be acknowledged that the majority of individuals do not have co-occurring disorders. The decision to merge the two agencies must weigh the benefit of this option of achieving integrated services for individuals with co-occurring disorders against the potential disruption to both agencies which serve a larger population of individuals with substance abuse or mental health disorders.

ADPA and DMH have different service delivery models. DMH uses primarily a clinical services model. ADPA on the other hand relies on a combination of peer support, self-help, social model and clinical interventions. Reports indicate that substance abuse agencies are often given lower priority when subsumed by much larger mental health agencies.[8] A merged mental health/substance abuse agency could result in a tiered system in which the clinical model services are favored over social model programs and services. The disparities in the size of the two organizations would enhance this effect.

Service Delivery for Co-occurring Populations

Both ADPA and DMH acknowledge the need for an integrated service approach to address the needs of individuals with co-occurring substance abuse and mental health disorders. One perspective holds that the transfer of ADPA is an approach to accomplish this. The other perspective holds that improved service integration can be

accomplished without the transfer, a view supported by a 2007 report from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Systems integration is viewed as a method of increasing access to and effectiveness of treatment of individuals with co-occurring substance abuse and mental health disorders. However, systems integration, while facilitating service integration, does not require the organizational merging of departments or programs. The 2007 SAMHSA report defined systems integration as, "The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families."[9] Moreover, the SAMHSA report further stated:

> *"Creation of an "integrated" State mental health and substance abuse department is in no way synonymous with systems integration. Depending on the system, creation of an integrated mental health and substance abuse department may provide a starting place for the organized integrated planning and implementation efforts that are requisites for systems integration. Alternatively, such a merger may create resistance within the existing systems that actually impedes the operationalization of systems integration efforts."*

Systems integration to provide optimal services to individuals with co-occurring disorders is possible if both DPH and DMH work together to create and implement appropriate programs and services. Below are characteristics identified by SAMHSA that promote systems working in an integrated manner:

- Committed leadership;
- Integrated system planning and implementation;
- Value-driven, evidence-based priorities;
- Shared vision and integrated philosophy;
- Dissemination of evidence-based technology to define clinical practice and program design;
- True partnership among all levels of the system; and,
- Data-driven, incentivized and interactive performance improvement processes.

Current Collaboration and Future Opportunities

ADPA and DMH are currently involved in 14 collaborative projects. The collaboration between the two organizations is established via an administrative agreement. Nine projects are delivered though DMH and five through ADPA for a total of $1,720,000. Eight of these programs provide service to clients with dual diagnoses or co-occurring disorders; four programs treat clients in crisis; and a final project funds an annual co-occurring disorders conference. It is imperative that these collaborations be extended to provide better integrated services for the co-occurring population at AVRC and to assure linkages to comprehensive services individuals with co-occurring disorders regardless of the initial point of intake.

Service collaboration and integration can be expanded and deepened between DPH and DMH via Memorandum of Understanding (MOU), with review by the CEO. The MOU approach yields results. DPH's current MOU with the Department of Health

Services has maintained and strengthened the relationships and collaboration between the two departments. The Leavey Center MOU for the provision of comprehensive services to homeless individuals is another example of DPH's involvement in a collaboration to provide integrated to a vulnerable population.

An MOU between DPH and DMH would not only facilitate the development and implementation of a set of integrated services for those with co-occurring disorders, but would also set the groundwork for additional collaboration between the two departments. As the reports discussed above indicate, the most important factors in establishing successful integrated services for those with co-occurring disorders is commitment from all parties.

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[1] M. Audrey Burnam and Katherine E. Watkins. Substance Abuse With Mental Disorders: Specialized Public Systems And Integrated Care. Health Affairs, May/June 2006; 25(3): 648-658.

[2] State Substance Abuse Agencies and Their Placement Within Government: Impact On Organizational Performance And Collaboration In 12 States, A. Gelger, D. Rinaldo, The Avis Group, November, 2005.

[3] See "1" above.

[4] M. Audrey Burnam and Katherine E. Watkins. Substance Abuse With Mental Disorders: Specialized Public Systems And Integrated Care. Health Affairs, May/June 2006; 25(3): 648-658.

[5] Center for Substance Abuse Treatment. The Epidemiology of Co-Occurring Substance Use and Mental Disorders. COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

[6] Center for Substance Abuse Treatment. The Epidemiology of Co-Occurring Substance Use and Mental Disorders. COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

[7] Los Angeles County, Department of Public Health Alcohol and Drug Program Administration Los Angeles County Participant Reporting System (Antelope Valley Rehabilitation Center Data) FY 2007-2008.

[8] State Substance Abuse Agencies and Their Placement Within Government: Impact On Organizational Performance And Collaboration In 12 States, A. Gelger, D. Rinaldo, The Avis Group, November, 2005.

[9] Center for Substance Abuse Treatment. Systems Integration. COCE Overview Paper 7. DHHS Publication No. (SMA) 07-4295. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

EXHIBIT C

ALCOHOL AND DRUG PROGRAM ADMINISTRATION
DEPARTMENT OF MENTAL HEALTH
FUNDING ANALYSIS
FISCAL YEAR 2008-09

FUNDING TO MENTAL HEALTH

	FISCAL YEAR 2008-2009			
	DESCRIPTION	MOS	DSO #	BUDGETED AMOUNT
1	Behavioral Health Services (BHS)	Dual Diagnosis Services	09MH0025	$ 125,000
2	Los Angeles Men's Place (LAMP) Contract	Provide support svcs. And housing for chronically homeless persons who are dual and multi-diagnosed with mental illness.	09MH0021	50,000
3	UCLA Extension Dual Diagnosis Training	Ten weeks course on co-occurring disorder, consisting of three distinct classes: Fundamentals, Biological perspective, Socio-cultural issues on co-occurring disorders.	09MH0022	22,000
4	AB 2034 Short Term Housing - Homeless	Provide short term shelter, beds for homeless clients	09MH0023	112,000
5	SAMI Peer Advocate Training	Peer Advocate Training	09MH0020	19,000
6	Social Model Recovery	Social Model Recovery	09MH0018	419,000
7	DMH Dual Diagnosis Coordinator	Dual Diagnosis Coordinator	09MH0019	54,000
8	Dual Diagnosis Program	Dual Diagnosis Services	09MH0024	361,000
9	Annual Co-Occurring Disorders Conference	Annual Co-Occurring Disorders Conference	09MH0026	25,000
	TOTAL			**$ 1,187,000**

FUNDING FROM MENTAL HEALTH

	FISCAL YEAR 2008-2009			
	DESCRIPTION	MOS	DSO #	BUDGETED AMOUNT
1	MHSA-Psych. Emerg. (Tarzana Treatment Center)	Community Assessment Service Center services (CASC)	09PG0012	$ 175,000
2	MHSA-Psych. Emerg. (Didi Hirsch Psychiatric Service)	Community Assessment Service Center services (CASC)	09PG0013	175,000
3	Dual Diagnosis (BHS)	Residential Services	09PG0009	120,000
4	Dual Diagnosis (LACADA)	Residential Services	09PG0010	38,000
5	Dual Diagnosis (Tarzana Treatment Center)	Outpatient Drug Court Counseling services	09PG0011	25,000
	TOTAL			**$ 533,000**

EXHIBIT D

2004-05 GRAND JURY REPORT

Excerpt, pages 33 – 37 of the 2004-05 Grand Jury Report regarding the Placement of Alcohol and Drug Program Administration.

Table 1.3

Co-Occurring Mental Health, Physical Health and Substance Abuse Diagnoses in the DMH High Utilizer Population FY 2002-03

Health Diagnosis	Mental Health Diagnosis: Bipolar Disease	Schizo-phrenia	Major Depression	Psychosis	Others	Total
Hypertension	49	71	245	2	24	391
COPD*	28	32	77	-	19	156
Diabetes	33	58	166	2	19	278
Others	460	586	1,354	14	465	2,879
Subtotal	570	747	1,842	18	527	3,704
Substance	333	520	612	6	265	1,736
Total	903	1,267	2,454	24	792	5,440
Sample Size	5,440	5,440	5,440	5,440	5,440	5,440
% w/Health	10.5%	13.7%	33.9%	0.3%	9.7%	68.1%
% w/Substance	6.1%	9.6%	11.3%	0.1%	4.9%	31.9%
% w/Both	16.6%	23.3%	45.1%	0.4%	14.6%	100.0%

Source: Department of Mental Health Study

As shown in the table, 68.1% of this subgroup of DMH clients also had primary physical health diagnoses that were being treated by the Department of Health Services. The remaining 31.9% also had primary substance abuse treatment diagnoses and were receiving services funded by ADPA. In total, DMH estimated that nearly $300 million in services were being provided to the "high utilizer" patient population in FY 2002-03.

Although only 31.9% of "high utilizer" DMH patients were also identified as having a primary substance abuse diagnoses, this percentage may not fully describe the degree to which mental health clients require substance abuse treatment. Although we were not provided data to support his assertion, the Mental Health Director has suggested that "probably 60 percent to 80 percent of *all* mental health clients also exhibit some form of drug or alcohol dependency."[9] Like the "high utilizer" population, many of these "dual diagnosed" patients receive services from both DMH and from contractors funded by the Alcohol and Drug Program Administration section of the DHS Public Health Division.

[9] This assertion has been challenged by DHS, who believe that the percentage of patients with co-occurring mental health and substance abuse diagnoses may range closer to 5% to 10% of the total DMH population.

There has been much controversy within the mental health and substance abuse communities regarding the relationships between the two populations of clients. During interviews we were advised that substance abuse clients generally do not want to be "stigmatized" by being associated with mental illness. On the other hand, mental health clients and their families see mental illness as a disease which encompasses much more than the substance abuse issues that are presented by the patients. Despite these perceptions, government agencies have been moving toward combined "behavioral health" organizations in recent years in an attempt to merge the two closely related services.

As the Board of Supervisors considers the County's healthcare organization after the creation of a health authority, it should examine the possibility of moving the Department of Mental Health and Alcohol and Drug Administration Program into a combined Behavioral Health Agency structure. This structure would provide opportunities to enhance interaction between the two services.

SUMMARY OF ORGANIZATIONAL ALIGNMENT FACTORS

Based on the analysis previously presented, DHS' hospitals, comprehensive health centers and other ambulatory care clinics should be transferred to the health authority. The responsibility for all other functions reviewed as part of this study should be retained by the County, including managed care, core public health, emergency medical services, juvenile court services, alcohol and drug treatment and mental health treatment services. The County should also look for opportunities to better align those healthcare related services that it retains, as discussed in this report.

Table 1.4

Organization Planning Matrix for Aligning Health Related Functions in Los Angeles County

	Primary Mission			Client Base			Preferred Alignment	
Program	Public Health	Physical Health	Behavioral Health	General County	Uninsured/ Indigent	Other	County	Health Authority
Hospitals		X			X			X
Ambulatory Care		X			X			X
Managed Care		X				X	X	
Core Public Health	X			X			X	
Emergency Medical Services		X		X			X	
Juvenile Court Services		X				X	X	
Alcohol & Drug Treatment			X			X	X	
Mental Health Treatment			X			X	X	

By aligning services in this manner, the health authority would be given a clear and focused mission, which would increase its chances of operational success. Regulatory, disease management, countywide coordination and health education functions would be retained by the County. By retaining the managed care function and expanding the current role to include health authority monitoring functions, the County would be better equipped to monitor the services and costs of the health authority.

By retaining the mental health and alcohol and drug program administration functions, behavioral health services will receive more focused attention and prominence in the organization. This is appropriate since both programs serve a broader population than just the uninsured and indigent residents of the County, and are more closely aligned with non-health services functions such as criminal justice and welfare.

By retaining responsibility for medical services provided to juveniles that are housed in County institutions, the Board of Supervisors will be better able to ensure appropriate levels and quality of care. The Board could choose to contract with the health authority to provide these services, as a supplementary service that would exceed the authority's statutory mandate.

Currently, the staff assigned to health services administration functions within DHS are shared by the programs some of which would be separated from the County when the health authority is created. As a result, decisions will need to be made regarding the allocation of administrative personnel and other resources between the health authority and the DHS divisions that remain as part of the County organization. The Board of Supervisors should direct the Chief Administrative Officer, with assistance from DHS, to determine the most appropriate allocation of personnel and resources as part of a health authority transition plan.

CONCLUSIONS

Several proposals to create a Los Angeles County health authority have been made over the past ten to fifteen years. However, the health services components included in each proposal have differed greatly and have been vaguely defined.

Previous proposals have not fully addressed whether responsibilities related to mandated Public Health or Mental Health services should be retained by the County or absorbed by the health authority. Further, these proposals have not consistently answered critical questions related to the complex responsibilities for providing indigent medical care services defined by California Welfare and Institutions Code Section 17000, case law and policy of the Board of Supervisors.

Before considering the complex governance, operational, funding or legal questions associated with the creation of an independent health authority, the Board of Supervisors, with input from DHS and the County's healthcare community, should clearly define the health authority's mission and functional components. A preferred model would transfer authority and responsibility for all physical health services to the health authority; would charge the health authority with the responsibility to provide specified levels of healthcare services to the uninsured and indigent; and, establish emergency and acute psychiatric care services in hard to serve areas of the County. Public Health services, Emergency Medical Services and other broad regulatory or coordination functions, should be

retained by the County. The Department of Mental Health should remain an independent County department that is separate from the health authority.

RECOMMENDATIONS

The Board of Supervisors, with input from DHS and the County's healthcare community, should:

1.1 Develop a clearly defined mission for the new health authority that is focused on the delivery of safety net physical health services for the uninsured and indigent populations within Los Angeles County.

1.2 Clearly define the minimum level of service to be provided by the health authority, based on Welfare and Institutions Code §17000 and case law.

1.3 Develop a structure that retains the County's responsibility for providing public health, mental health, drug and alcohol, emergency medical, managed care and juvenile court health services.

The Board of Supervisors should:

1.4 Retain the Department of Mental Health as a distinct County department not under the jurisdiction of the new health authority.

1.5 Establish Public Health as a distinct County department not under the jurisdiction of the new health authority.

1.6 Consider placing the Emergency Medical Services function under the authority of the Public Health Officer.

1.7 Consider placing Managed Care under the authority of the Public Health Officer, and expanding its role to include the monitoring of health services provided by the health authority under its contract with the Board of Supervisors.

1.8 Consider placing the Alcohol and Drug Program Administration function under the Department of Mental Health and creating a Behavioral Health Department.

1.9 Retain responsibility for health services functions provided to juveniles who are in County institutions (Juvenile Court Services), but contract with the health authority or another provider to provide such services.

1.10 Direct the Chief Administrative Officer, with assistance from DHS, to determine the most appropriate allocation of DHS Health Services Administration personnel and resources as part of a health authority transition plan.

COSTS AND BENEFITS

There would be no direct cost to implement these recommendations. However, staff time would be required to provide the analyses that will be necessary for the Board of Supervisors to make informed decisions.

The health authority would be given a clear and focused mission, which would increase its chances of operational success. Regulatory, disease management, countywide coordination and health education functions would be retained by the County. By retaining the managed care function and expanding its current role, the County would be better equipped to monitor the services and costs of the health authority.

By retaining the mental health and alcohol and drug program administration functions, the behavioral health services will receive more focused attention and prominence in the organization. This is appropriate since both programs serve a broader population than just the uninsured and indigent residents of the County, and are more closely aligned with non-health services functions such as criminal justice.

By retaining responsibility for medical services provided to juveniles that are housed in County institutions, the Board of Supervisors will be better able to ensure appropriate levels and quality of care. The Board could choose to contract with the health authority to provide these services, as a supplementary service that would exceed the Authority's statutory mandate.

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

State of California – California Health & Human Services Agency *http://www.chhs.ca.gov/Pages/default.aspx*	
Department of Health Care Services *http://www.dhcs.ca.gov/Pages/default.aspx*	▪ California Children's Services ▪ Child Health and Disability Prevention ▪ Children's Medical Services
Department of Public Health *http://www.cdph.ca.gov/Pages/default.aspx*	▪ External Affairs ▪ Binational Border Health ▪ Legislative and Governmental Affairs ▪ Multicultural Health ▪ Public Affairs ▪ Women's Health ▪ Policy and Programs ▪ Coordinating Office for Obesity Prevention ▪ Emergency Preparedness Office ▪ Health Information and Strategic Planning ▪ State Laboratory Director ▪ Center for Chronic Disease and Health Promotion ▪ Center for Chronic Disease and Health Promotion ▪ Chronic Disease and Injury Control ▪ Environmental and Occupational Disease Control ▪ Center for Environmental Health ▪ Center for Environmental Health ▪ Drinking Water and Environmental Management ▪ Food, Drug, and Radiation Safety ▪ Center for Family Health ▪ Center for Family Health ▪ Family Planning ▪ Genetic Disease Screening Program ▪ Maternal, Child, and Adolescent Health ▪ Women, Infants, and Children
Department of Public Health ***continued*** *http://www.cdph.ca.gov/Pages/default.aspx*	▪ Center for Healthcare Quality ▪ Center for Healthcare Quality ▪ Laboratory Field Services ▪ Licensing and Certification ▪ Center for Infectious Disease ▪ Center for Infectious Disease ▪ AIDS ▪ Communicable Disease Control

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

Department of Alcohol and Drug Programs *http://www.adp.ca.gov/*	The **Department of Alcohol and Drug Programs** is responsible for administering prevention, treatment, and recovery services for alcohol and drug abuse and problem gambling. ▪ Treatment ▪ Resource Center ▪ Youth Services ▪ Women's Programs ▪ Problem Gambling ▪ Driving Under the Influence Programs ▪ California Access to Recovery Effort (CARE) ▪ Co-Occurring Disorders
Department of Mental Health *http://www.dmh.cahwnet.gov/*	California's public mental health system offers an array of community and hospital-based services that are available to adults who have a serious mental illness and children with a severe emotional disorder. ▪ Rehabilitation and support ▪ Evaluation and assessment ▪ Vocational rehabilitation ▪ Individual service planning ▪ Residential treatment ▪ Medication education and management ▪ Case management Groups ▪ Wrap-around services ▪ State Hospitals ▪ Forensic Programs ▪ Children & Youth Services ▪ Adult Services ▪ Quality Oversight

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

Orange County – Health Care Agency *http://www.ochealthinfo.com/*	
Behavioral Health Services	Culturally-competent and client-centered system of behavioral health services for all eligible county residents in need of mental health care and/or treatment for alcohol and other drug abuse. ▪ Adult Mental Health Services ▪ Children and Youth Mental Health Services ▪ **Alcohol and Drug Abuse Services**
Medical & Institutional Health	Emergency medical care, medical and behavioral health care to adults and children in institutional settings, and contracted essential medical services for patients for whom the County is responsible. ▪ Health Disaster Management (HDM) ▪ Emergency Medical Services (EMS) ▪ Disaster Preparedness and Training ▪ Medical Reserve Corps (MRC) ▪ Institutional Health Services (IHS) ▪ Medical Services Initiative (MSI)
Public Health Services	Public Health Services monitors the incidence of disease and injury in the community and develops preventive strategies to maintain and improve the health of the public. Ensures food safety, water quality and protects the public's health and safety from harmful conditions in the environment, from animal-related injury, and from disease and nuisance hazards through the enforcement of health and safety standards. ▪ California Children's Services ▪ Disease Control and Epidemiology ▪ Environmental Health ▪ Family Health ▪ Health Promotion ▪ Laboratory ▪ Nursing ▪ Public Health Administration ▪ Healthy Families Assistance Programs

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

San Bernardino County *http://www.co.san-bernardino.ca.us/*	
Department of Behavioral Health *http://www.co.san-bernardino.ca.us/dbh/*	Behavioral Health Programs strive to be recognized as a progressive system of seamless, accessible and effective services that promote prevention, intervention, recovery and resiliency for individuals, families and communities. ▪ Adult Services ▪ **Alcohol& Drug Services** ▪ Children Services ▪ Forensic Services ▪ Outpatient Services
Department of Public Health *http://www.sbcounty.gov/pubhlth/Default.aspx*	The Department of Public Health works to prevent epidemics and the spread of disease, protect against environmental hazards, prevent injuries, promote and encourage healthy behaviors, respond to disasters and assist communities in recovery, and assure the quality and accessibility of health services throughout the county. ▪ Public Health Clinics ▪ Preparedness & Response ▪ Animal Care & Control ▪ Nursing Services ▪ Environmental Health Services

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

Riverside County *http://www.countyofriverside.us/portal/page/portal/comew*	
Department of Mental Health *http://mentalhealth.co.riverside.ca.us/opencms/*	The Department provides effective and culturally sensitive community-based services that enable adults who are mentally disabled, adults who are older, children who are at risk of mental disability, substance abusers, and individuals who need conservatorship, to achieve their optimal level of healthy personal and social functioning. ▪ Adult Mental Health Services ▪ Older Adult Mental Health Services ▪ Children's Services ▪ Public Guardian ▪ **Substance Abuse Program**
Department of Public Health *http://www.rivcoph.org/*	The Department of Public Health promotes and protects the health of all County residents and visitors in service of the well-being of the community. ▪ Family Care Centers – Health Care ▪ Disease Control ▪ Maternal, Child & Adolescent Health ▪ Children's Medical Services ▪ Public Health Nursing ▪ Nutrition & WIC Services ▪ Health Promotion and Professional Development ▪ Public Health Laboratory ▪ Industrial Hygiene ▪ Emergency Medical Services ▪ Emergency Preparedness and Response ▪ Injury Prevention Services ▪ HIV/AIDS Program ▪ Medical Marijuana Identification Card ▪ Family Planning ▪ Epidemiology & Program Evaluation ▪ Vital Records ▪ Community Outreach

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

San Diego County – Health and Human Services Agency *http://www2.sdcounty.ca.gov/hhsa/*	
Behavioral Health *http://www2.sdcounty.ca.gov/hhsa/programs ervices.asp?ProgramID=3* **Behavioral Health *continued*** *http://www2.sdcounty.ca.gov/hhsa/programs ervices.asp?ProgramID=3*	Behavioral Health includes a continuum of services aimed at providing an array of mental health, alcohol and other drug services for children, youth, families, adults, and older adults, and improving the quality of life within communities. Behavioral health services include prevention, treatment, and interventions that promote recovery and social well-being. ▪ **Alcohol and Drug Services (ADS)** ▪ Adolescent Treatment Services – non residential ▪ Adolescent Treatment Services – residential ▪ Adult Treatment Services – non residential ▪ Adult Treatment Services – residential ▪ Adult Treatment Services – Detox ▪ Driving Under the Influence Program ▪ HIV Counseling and Testing ▪ Methamphetamine Strike Force ▪ PC 1000 Program/AIDS Education ▪ Prevention Services ▪ Inpatient Health Services ▪ Mental Health Services – Adult and Older Adult ▪ Mental Health Services – Children
Public Health *http://www2.sdcounty.ca.gov/hhsa/programs ervices.asp?ProgramID=4*	Public Health Services is dedicated to community wellness and health protection. Public Health Services works to prevent epidemics and the spread of disease, protect against environmental hazards, prevent injuries, promote and encourage healthy behaviors, respond to disasters and assist communities in recovery and assure the quality and accessibility of health services. ▪ Black Infant Health Program ▪ Border Health Program ▪ Child Health and Disability Prevention Program ▪ Childhood Lead Poisoning Prevention Program ▪ Chronic Disease and Health Disparities ▪ Community Epidemiology ▪ Community Health Statistics ▪ Comprehensive Perinatal Services Program ▪ CureTB: Binational TB Referral Program ▪ Dental Health Initiative/Share the Care ▪ Emergency Medical Services ▪ HIV, STD and Hepatitis Branch ▪ Immunization Branch ▪ Maternal, Child and Family Health Services ▪ Office of Violence Prevention ▪ Office of Vital Records and Statistics

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

	▪ HIV/AIDS Epidemiology Unit ▪ Public Health Laboratory ▪ Public Health Nursing ▪ Tobacco Control Resource Program ▪ Tuberculosis Control Program
Ventura County - Health Care Agency *http://portal.countyofventura.org/portal/page?_pageid=953,1&_dad=portal&_schema=PORTAL*	
Behavioral Health *http://portal.countyofventura.org/portal/page?_pageid=953,1293790&_dad=portal&_schema=PORTAL*	The Behavioral Health Department is dedicated to relieving suffering and enhancing recovery from mental illness, alcohol and other drug problems, through leadership in education, training, service, and policy advocacy. ▪ **Alcohol and Drug Programs** ▪ Children's Services ▪ Adult Services ▪ Quality Improvement ▪ Mental Health Services Act (MHSA) ▪ Drinking Driver ▪ Crisis Team ▪ Managed Care
Public Health *http://portal.countyofventura.org/portal/page?_pageid=953,1293789&_dad=portal&_schema=PORTAL*	The Department of Public Health's goals are to prevent illness, injuries and the spread of disease, assure highest quality and accessible health services, promote and encourage healthy behaviors, and to respond to disasters and assist communities in recovery. ▪ Children's Health Care ▪ Flu Clinics ▪ Disease and Control Prevention ▪ Community Nursing and Health Education ▪ Family Health ▪ Emergency Preparedness

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

	Alcohol & Drug Programs *(As its own Department)*	Department of Behavioral Health	Department of Mental Health	Department of Public Health
LA County				√
State of California	√			
Orange County		√		
San Bernardino County		√		
Riverside County			√	
San Diego County		√		
Ventura County		√		

California Performance Review

HHS15 Consolidate the State's Mental Health and Alcohol and Drug Programs to Better Serve Californians

Summary

California administers its alcohol, drug and mental health programs in two separate agencies. Consolidating the management of these behavioral health programs will improve coordination of county administered services to persons suffering from both mental illness and substance use disorders.

Background

California's alcohol and drug programs are administered by the Department of Alcohol and Drug Programs (ADP) with most services operated by or through counties. California's mental health programs are administered by the Department of Mental Health (DMH).

For Fiscal Year 2004-2005, ADP is budgeted for 356 positions to administer approximately $591 million in total funds. DMH is budgeted for 9,183 positions to administer approximately $2.5 billion to fund the state hospitals and community services. Within DMH are 318 headquarters positions not directly related to state hospital operations to administer approximately $1.8 billion in total community services funds.[1] Virtually all community mental health services are delivered by or through counties in concert with more than $650 million in mental health funds which go directly to counties rather than through the DMH budget.[2]

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports that more than half the people diagnosed with a mental disorder also have an alcohol or other drug-related disorder, and of those persons diagnosed with serious mental illness, 41 percent have alcohol or other drug disorders.[3] Persons suffering from serious and persistent mental illness who are involved with the criminal justice system have been estimated to have co-occurring substance abuse disorders at rates as high as 82 percent.[4] According to SAMHSA, "The most common cause of psychiatric relapse today is use of alcohol, marijuana, and cocaine. The most common cause of relapse of substance use/abuses today is untreated psychiatric disorder."[5]

Inadequate and ineffective treatment of substance abuse and mental illness not only destroys lives, but also manifests in costs and problems in virtually all government programs including health care, education, housing/homelessness and particularly adult and juvenile justice systems. Experience with treating persons diagnosed with both mental illness and substance abuse disorders-known as co-occurring disorders-indicates that merging treatments produces better results.[6]

The Substance Abuse and Mental Health Services Administration recently completed the first in a series of policy reviews on co-occurring disorders. According to SAMHSA Chief of Staff Gail Hutchings, there was clear consensus from behavioral health officials representing ten states that integrated treatment is the preferred option for persons with co-occurring disorders.[7] However, many people in the addiction field fear that merging addiction and mental health responsibilities will reduce the visibility of alcohol and drug treatment and prevention.[8]

Over the last twenty years, public mental health treatment in California has been moving from a "medical model" in which decisions were made exclusively by professional treatment staff- primarily psychiatrists and psychologists-to a "recovery model" in which the consumer participates fully in treatment planning and implementation. The mental health recovery approach is becoming increasingly like that employed by alcohol and drug treatment programs. At the same time, the alcohol and drug abuse treatment field is becoming more professional with greater certification of treatment providers and staff. The increasing similarities in the treatment approaches, however, are not fully understood or appreciated by the two disciplines.

While alcohol and drug programs include an effective focus on prevention, mental health has not developed a useful prevention strategy. Public mental health treatment programs have greatly increased involvement of consumers and family members in all aspects of program administration. Mental health treatment is generally regarded as employing a systems approach while alcohol and drug services have evolved more as a collection of services. Each system could benefit from association with the other. Robert Nikkel, Administrator of Oregon's Office of Mental Health and Addiction Services, reports that placing both functions together in Oregon was disruptive at first, but has produced considerable benefit for both service systems over time.[9]

Twenty-five other states have merged their mental health and substance abuse program functions. The National Association of State Mental Health Program Directors (NASMHPD) reports that while the reorganization trend of the 1980s and early 1990s split mental health and substance abuse services, the trend now appears to be moving toward consolidating both functions into the same agency.[10]

Thirty-eight California counties have merged local departments dealing with mental health and substance abuse.[11] While most counties that have merged alcohol and other drug (AOD) and mental health (MH) responsibilities report improved services to persons dually diagnosed with mental illness and substance abuse disorders, counties struggle to employ expensive "work arounds" in which a great deal of administrative work is done to ensure proper bookkeeping to integrate mental health and substance abuse services. Two counties-San Bernardino and Stanislaus-report keeping two sets of books to overcome some of the obstacles created by separate state operations.[12] San Francisco County reports its biggest administrative challenge may well be relating to two separate and unconnected departments at the state level.[13]

Monterey County is reportedly better able to serve Temporary Assistance for Needy Families (TANF) referrals since they merged their systems in 1996.[14] Stanislaus County has integrated its service teams to include AOD and MH specialists without "homogenizing," but instead, emphasizing the unique clinical strategies and values of each field. Clients enter the same door, and when receiving both AOD and MH services, are tracked in one chart.[15] Alameda County reports significant benefit from having previously separated program management staff sitting at the same table helping each other solve problems while gaining better understanding and appreciation of each other's professional culture.[16] San Francisco reports developing a number of highly effective combined programs, such as multiple diagnosis medically supported detox, dual diagnosis residential programs, dual diagnosis outpatient care, and providing substance abuse medication protocols to mental health physicians.[17] No county responding to the question of potential for loss of emphasis on AOD services reported any such loss.

Recommendation

A. The Health and Human Services Agency, or its successor, should consolidate the administration of the state's substance abuse and mental health programs.

Fiscal Impact

Savings of approximately $1.8 million annually should accrue from elimination of duplicate functions and staff. At a minimum, the following positions should be eliminated: one director, one chief deputy director, one chief counsel, one public information officer, one deputy director/chief of legislation, one deputy director for administration, one deputy director/chief of information technology.

In addition, 10 percent of the Department of Alcohol and Drug Program administrative services and 5 percent of the Department of Mental Health administrative services could be eliminated. The reason for reducing DMH administrative services by only 5 percent presumes that the Department of Behavioral Health would continue to operate the state hospital system.

TOTAL FUNDS (dollars in thousands)

Fiscal Year	General Fund Savings	Federal Fund Savings	Other Fund Savings	Total Net Savings	Change in PYs
2004-05	$0	$0	$0	$0	$0
2005-06	$180	$1,653	$20	$1,853	(10)
2006-07	$180	$1,653	$20	$1,853	(10)
2007-08	$180	$1,653	$20	$1,853	(10)
2008-09	$180	$1,653	$20	$1,853	(10)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003-2004 expenditures, revenues and PYs.

Endnotes

[1] California Department of Finance, "Governor's Budget 2004-2005," (Sacramento, California, January 2004). pp. HHS 21 and HHS 102.

[2] Interview with Stan Johnson, chief, County Financial Program Support, California Department of Mental Health, Sacramento, California (May 25, 2004).
[3] Substance Abuse and Mental Health Services Administration, "Report to Congress on Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders" (Rockville, Maryland, 2002), p. 1.
[4] California Board of Corrections, "Mentally Ill Offender Crime Reduction Grant Program Annual Legislative Report" (Sacramento, California, 2002), p. 2.
[5] Substance Abuse and Mental Health Services Administration, "Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders" (Rockville, Maryland, January, 1997), p. 1.
[6] Substance Abuse and Mental Health Services Administration, "Report to Congress on Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorder" (Rockville, Maryland, 2002), p. 15.
[7] E-mail from Gail P. Hutchings, M.P.A., chief of staff, Substance Abuse and Mental Health Services Administration, to California Performance Review (May 17, 2004).
[8] Interview with Toni Moore, administrator, Sacramento County Alcohol and Drug Program Administration, and Patrick Ogawa, director, Los Angeles County Alcohol and Drug Program Administration, Sacramento, California (March 16, 2004).
[9] E-mail from Robert Nikkel, administrator, Oregon Office of Mental Health and Addiction Services, to California Performance Review (May 10, 2004).
[10] National Association of State Mental Health Program Directors Research Institute, Inc., "State Mental Health Agency Organization and Structure: 2003," No. 03-10 (Alexandria, Virginia, January 2004), pp. 1-2.
[11] Interview with Jim Featherstone, director, Napa County Mental Health, and Marvin Southard, DSW, director, Los Angeles County Department of Mental Health, board members, California Mental Health Directors Association, Sacramento, California (March 10, 2004).
[12] Interview with Larry Poaster, PhD, director, Stanislaus County Department of Behavioral Health, retired, Modesto, California (March 30, 2004); and interview with Rudy Lopez, director, San Bernardino County Behavioral Health, San Bernardino, California (April 9, 2004).
[13] E-mail from James Stillwell, program manager, San Francisco Behavioral Health, to California Performance Review (April 12, 2004).

[14] E-mail from Robert Egnew, director, Monterey County Department of Behavioral Health, retired, to California Performance Review (April 1, 2004).
[15] E-mail from Dan Souza, director, Stanislaus County Department of Behavioral Health, to California Performance Review (April 1, 2004).
[16] Interview with Marye Thomas, MD, director, Alameda County Behavioral Health, Oakland, California (April 8, 2004).
[17] E-mail from James Stillwell.

EXHIBIT G

CAADPE

CALIFORNIA ASSOCIATION OF ALCOHOL AND DRUG PROGRAM EXECUTIVES, INC.

William T. Fujioka
Los Angeles County, Chief Executive Officer
713 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

January 13, 2009

Dear Mr. Fujioka,

I am writing on behalf of California Association of Alcohol and Drug Program Executives, Inc. (CAADPE), Southern California Chapter in regards to Supervisor Antonovich's motion to consolidate the office of Alcohol and Drug Programs with the Los Angeles County Department of Mental Health.

It is our understanding this matter is currently under review by your office with a report due back to the Board of Supervisors in March, 2009. Consistent with your review efforts considering this matter, CAADPE wishes to meet and discuss the issue with you. We think it is imperative you take into account our perspective on this issue and that you consider and digest the enclosed attachments which address the notion of merging Mental Health and AOD Departments.

Attachments include:

1. Organizational Placement of State Substance Abuse Agencies: Impact on organizational performance
2. CADPAAC response to Health and Human Services Agency Stakeholder Survey – California Performance Review Recommendations
3. Analysis of CPR Recommendation to Consolidate Mental Health and Alcohol and Drug Programs
4. ACHSA Issues/Concerns Re: Potential Merger of ADPA with LACDMH

Assuming your willingness to meet, I will ask my office to contact your office to set up a time that works for both.

If you have any questions or require any further information, please contact me at 818-654-3815.

Respectfully,

Albert M. Senella
President CAADPE, Chair Southern CA Chapter

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ORGANIZATIONAL PLACEMENT OF STATE SUBSTANCE ABUSE AGENCIES:

IMPACT ON ORGANIZATIONAL PERFORMANCE

August 16, 2004

Report on Phase I Analysis

The Avisa Group
1117 Euclid Avenue
Berkeley, CA 94708

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ACKNOWLEDGEMENTS AND METHODOLOGY

ACKNOWLEDGEMENTS

This study was performed by the Avisa Group on behalf of the California Department of Alcohol and Drug Programs (ADP). This study was supported by the Center for Substance Abuse Treatment (CSAT) State Systems Division, part of the Substance Abuse and Mental Health Services Administration (SAMHSA), through Contract No. 270-00-7071 with Health Systems Research, Inc (HSR). Terrence Schomberg, Ph.D. is the government project officer for this contract and William Ford, Ph.D., is the HSR project director for this study.

States were given an opportunity to review their own State descriptions and make comments and suggestions, many of which are incorporated here. In addition, senior staff of California ADP, William Ford, Ph.D. of HSR and three expert reviewers made comments and suggestions that are incorporated into this document. Remaining errors are the responsibility of the Avisa Group. The observations and views expressed herein are attributable to the Avisa Group and no endorsement by ADP, CSAT, SAMHSA or HSR is intended or should be inferred.

METHODOLOGY AND NEXT STEPS

Nine States were initially selected for inclusion in this phase of this qualitative study by California ADP and Avisa; these States were selected to represent different governmental organizational configurations and were selected from the nineteen most populous States because California is so large and diverse and comparisons to smaller states would not be appropriate. Structured interviews and follow-up discussions with State Directors and their key staff from each State Substance Abuse agency were conducted on site in three States: New York, Texas and Washington. In the other six States, structured interviews with Directors and their key staff were conducted by telephone. Additional information primarily related to expenditures was also requested from each State. A copy of the discussion guide used both in the telephone and the on-site interviews is appended.

An initiative to add three more States of interest, to conduct additional site visits and to add perspectives from other major constituents in each State has been

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approved by CSAT and is currently underway, with a final report expected in November 2004.

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EXECUTIVE SUMMARY

- State substance abuse services and policy are critical components of State government functions. Undetected, unprevented and untreated substance abuse problems impose significant costs on health care, on other State agencies and on other components of the community. States vary both in the extent of their substance abuse problem and in the prominence of their State substance abuse agencies within the State government.

- In order to implement substance abuse policy and services that will actually achieve the objective of reducing direct and indirect costs of substance abuse, effective collaboration between the substance abuse agency and multiple other State and community agencies is required. This need for interagency collaboration is greater for substance abuse than for almost any other health or human services agency because virtually every public agency has clients with substance abuse disorders.

- To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within an agency that does not fully share its priorities and mission.

- The organizational placement of a State substance agency is one major variable explaining the autonomy, visibility and resources of State substance abuse agencies. Agency leadership and personal expertise and connections of the Directors and key staff also play important roles but they can be stymied if structure does not permit them to exercise that expertise or collaborative initiatives easily.

- One of the most important determinates of agency autonomy, and one that is highly correlated with organizational placement, is whether or not the State agency Director is appointed by the Governor. Appointment of the State agency Director by the Governor confers authority, credibility and status, as well as clearly indicating the priority of substance abuse issues within State government.

- Substance abuse agencies that are in the lower echelons of the State bureaucracy and do not have sufficient visibility, adequate staff or other resources, report that they are simply unable to advance significant substance abuse education, prevention, treatment and policy objectives that are held jointly with other agencies, especially including criminal justice and law enforcement.

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- State substance abuse agencies with high visibility in the State system and a corresponding allocation of resources reported being able to promote effective substance abuse policy through the agency's status, visibility, credibility with a strategy of interagency collaboration. These agencies also report being better able to devote internal resources to the effort required to obtain discretionary Federal funds.

- SSA's that are directly supported either by a drug Czar or where the SSA Director and staff have direct and positive relationships with the criminal justice/corrections system through other mechanisms also reported that they were better able to function efficiently and effectively as agencies.

- Several Directors and their executive staff emphasized the key role of leadership in the success of their SA agency, regardless of its organizational position within State government. However, the exercise of any type of leadership requires resources.

- Substance use and abuse is an important issue in the treatment of those with severe mental illness (SMI) or severe emotional disorders (SED). Collaboration with the State substance abuse agency is of critical importance for State mental health agencies. Collaboration with the State mental health agency is a key function for State substance abuse agencies. However, treating co-occurring disorders is more of a programmatic and clinical issue than an organizational placement issue within state government.

- The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency or State government that the ability of the mental health agency to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control. However, the evidence developed to date in this nine State study clearly indicates that this submersion would significantly degrade the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to its collaboration with the mental health agency.

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FINDINGS

IMPORTANCE OF STATE SUBSTANCE ABUSE SERVICES AND POLICY

State substance abuse services and policy are critical components of State government functions. This is true despite the relatively small portion of State budgets devoted to substance abuse issues. Among the major sectors that are affected by substance abuse-related issues are public and private health care, public welfare and social services, public safety, accidents and violence, housing, education, adult and juvenile criminal justice and corrections, education, vocational rehabilitation, commerce/labor and economic development. Two clusters of issues explain the disparity between the critical importance of the issue of substance abuse to the States and the amount of direct spending by States on substance abuse education, prevention and treatment services.

First, undetected, unprevented and untreated substance abuse problems impose significant costs on health care and other components of the community[1], including:

1. Primary and specialty health care services and systems, especially including infectious disease and obstetrics
2. Public safety, violence and accidents
3. Child welfare
4. Criminal justice
    a. Law enforcement and the court system
    b. Jails, prisons and parole systems
    c. Juvenile justice
    d. Incarceration alternatives
5. Housing
6. Education and Vocational Rehabilitation
7. Mental health

Second, State substance abuse spending fluctuations, often related to budget deficits or surpluses, may be accompanied by corresponding changes in Federal support, causing a multiplier effect on State spending for substance abuse services. In addition, Federal Maintenance of Effort (MOE) requirements associated with the Substance Abuse Prevention and Treatment (SAPT) Block Grant stipulate that States must keep their State and/or county spending for

[1] Office of National Drug Control Policy (2001). *The Economic Costs of Drug Abuse in the United States, 1992-1998.* Washington, DC: Executive Office of the President (Publication No. NCJ-190636).

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substance abuse education, prevention and treatment at the previous year's level, no matter how large or small that level is, in order to retain the same level of Federal support. States failing to maintain their specified substance abuse State-funding levels are subject to a proportionate reduction in Federal funding under the SAPT Maintenance of Effort Requirements. Several States that Avisa examined have either been cited for MOE problems already or fear that they will be cited, causing fiscal uncertainty that affects planning, operations and interagency collaboration. Thus, reductions in State spending may incur a multiplier effect by causing a concomitant reduction in Federal spending.

Many States provide some substance abuse treatment services as an optional benefit under their Medicaid programs. State dollars spent for services covered by Medicaid are also matched according to a formula by Federal dollars, providing for a second multiplier effect that works in both directions. Therefore, spending by States for substance abuse education, prevention and treatment has an impact on health and welfare disproportionate to its size due both to the mechanisms of Federal support and to the corresponding impact of changes in spending on the direct and indirect economic and social costs of substance abuse and dependence. It is of note that both mechanisms of Federal support work to reduce Federal spending when State spending declines, but only Federal Medicaid support increases when State Medicaid expenditures increase.

ROLE OF COLLABORATION IN IMPLEMENTING SUBSTANCE ABUSE POLICY

In order to implement substance abuse policy and services that will actually achieve the objective of reducing direct and indirect costs of substance abuse, effective collaboration between the substance abuse agency and multiple other State and community agencies is required, according to all of the respondents interviewed. This need for interagency collaboration is greater for substance abuse than for almost any other health or human services agency.

To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within another agency that does not fully share its priorities, requirements and mission. One of the most important determinates of autonomy and visibility, and one that is highly correlated with organizational placement, is whether or not the State agency Director is appointed by the Governor. The State substance abuse agency must be perceived by other agencies and legislative/gubernatorial staff to have sufficient importance, status and clout within State government in order for them to be willing to spend scarce time, staff and effort at a time of competing

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priorities in effective collaboration. This makes it possible to develop and implement effective and efficient initiatives that maintain and optimize SA clinical service integrity and quality, while providing services to SA clients of other State departments. Attracting additional resources through active collaboration also provides the ability to devote resources to the effort required to obtain additional discretionary grant funds from Federal agencies that provide funding for substance abuse services, which in turn confers credibility with other State departments and the legislature.

This review of substance abuse agencies in nine large States indicated that SA agencies that lacked Gubernatorial appointment status, were in the lower levels of the State bureaucracy and did not have sufficient visibility, adequate staff or other resources, were simply unable to advance significant substance abuse education, prevention, treatment and policy objectives that are held jointly with other agencies, including criminal justice. One result was that these State substance abuse agencies appeared to be dominated by other constituencies such as providers and the substance abuse system responded primarily to the concerns and interests of these constituents rather than being able to focus more on the needs of the substance abuse clients and others negatively affected by substance abuse. The organizational placement of a State substance agency is one major variable explaining the visibility and resources of State substance abuse agencies. Agency leadership and personal expertise and connections of the Directors and key staff also play important roles but they can be stymied if structure does not permit them to exercise that expertise or participate in and initiate collaborative efforts easily.

ORGANIZATIONAL PERFORMANCE OF STATE SUBSTANCE ABUSE AGENCIES

This study indicates that State substance abuse agencies with high visibility in the State system and a corresponding allocation of resources report being able to promote effective substance abuse policy. This is accomplished through the agency's status, credibility and strategy of collaboration with other agencies throughout State government that enables the SSA to serve clients with substance abuse disorders who are often clients of other State systems. SSA's that were directly supported either by a cabinet-level drug Czar or where the SSA Director or staff have direct relationships with the criminal justice/corrections system through mechanisms, such as the SSA Director sitting on the State's drug demand reduction council or having professional experience in the criminal justice agency (CA, FL and MI), also reported that they were better able to

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function efficiently and effectively. A summary of these perceived organizational performance measures appears in Table I below.

TABLE I

PERCEIVED ORGANIZATIONAL PERFORMANCE

STATE	SSA DIRECTOR APPOINTED BY GOVERNOR	SUCCESS IN MOE	EXTENT OF COLLABORATION WITH OTHER AGENCIES	ABILITY TO MOUNT SA POLICY INITIATIVE
Florida	Y*	Y	H	H
Georgia	N	Y	L	L
Massachusetts[2]	N	N	L	L
Michigan	Y	Y[3]	H	H
New York	Y	Y	H	H
North Carolina	N	Y	H	M
Ohio	Y	Y	H	H
Texas[4]	N	Y	M	M
Washington	N	Y	H	H

N, Y No, Yes
H, M, L High, Medium, Low

* Director of Florida Office of Drug Control (ODC) appointed by Governor. Director of SSA, who is dually appointed to ODC and the State SA Agency, is not appointed by the Governor

SIGNIFICANT SUBSTANCE ABUSE POLICY ISSUES

State Directors and their staff raised a number of general substance abuse policy issues that were broadly relevant beyond the borders of their individual States. In addition to the specific organizational issues discussed in more detail in subsequent sections of this report, the following significant substance abuse policy issues were emphasized by State Directors:

[2] Massachusetts – Extensive collaboration and policy development within Department of Public Health, focused on prevention mission
[3] Michigan – Problems with MOE requirement prior to reorganization
[4] Texas - Planning for reorganization of State agencies has disrupted collaboration and SA policy development

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Leadership

- Several respondents emphasized the key role of leadership in the success of their SA agency, regardless of its organizational position within State government. Although this attribution of the success of their agencies to the exercise of leadership by the Director and his/her key staff could be partly self-congratulatory, there appears to be a core of truth to this assertion.

- The exercise of any type of leadership requires resources. A Director and senior staff in an agency with severe resource constraints and very few staff members will be unable to devote the resources of the agency to leadership and interagency, intergovernmental activities. Even though such an agency could provide services to clients of many of these other departments, it will, instead, be forced to devote all available resources toward fulfillment of the agency's Federal and State required missions alone because of resource constraints. Although some of these missions require providing services to individuals who are also clients of other agencies, it is only the minimum number of required tasks that can be accomplished.

- The ability to exert leadership is fostered by staff and funding stability and continuity. Agencies with continuity in the positions of the Director and key staff, as well as having records of funding stability, report that they have more ability to be leaders in the State and in combating substance abuse.

- Policy leadership requires agency and staff collaboration with other entities, especially in SA, which provides services to many people who are also clients of other departments; effective inter-agency collaboration based on shared utilization and outcomes data is perhaps the most effective strategy to accomplish SA policy goals. However, collaboration requires funding and staff resources as well as autonomy, visibility and clout, in order to convince other State and community agencies to collaborate.

- Some respondents felt that reliance on personal leadership instead of organizational structure provided only a temporary solution to substance abuse policy imperatives when a longer term solution of structural autonomy was needed to assure effective State-funded substance abuse services.

Relationship to Mental Health Agency

- There are important differences between the substance abuse and mental health policy environments:

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- Mental health treatment is an entitlement for most individuals with severe mental illness. Departments of Mental Health aim to provide services to as many of these persons as possible because they are mandated to do so.

- In comparison, substance abuse treatment services are made available only to about twenty percent of those who are members of the substance dependent population, rather than to the entire target population.

- Substance abuse agencies and mental health agencies may be organizationally close to or distant from one another in State government. However, substance abuse spending in States is much lower than mental health spending, which generally implies that substance abuse agencies are smaller. The sources of funding for mental health and substance abuse are quite different from one another.

    - Federal funding other than Medicaid and Medicare provides 16% of the funds for substance abuse but only 4% for mental health[5]. These funds are primarily from the Federal Block Grant Programs for substance abuse and for mental health.

    - Medicaid, a joint State-Federal program, provides substantially greater support of mental health services than of substance abuse treatment services, in part due to the Federal stipulation that people who are disabled due to drug addiction or alcoholism are ineligible for Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) benefits and, therefore, Medicaid coverage linked to these programs. SSDI and SSI remain important sources of support for individuals (children, adolescents and adults) with a mental health disability.

    - Substance abuse treatment services fall under the optional services that States can elect to cover or not cover under Medicaid.

    - For the nation as a whole, total State and Federal public expenditures for mental health are 5.5 times the public expenditures for substance abuse, and State expenditures for mental health are 6.2 times those of State expenditures for

[5] SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1997* DHHS Publication No. SMA 003499 2000

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substance abuse[6]. In comparing State spending for mental health and substance abuse, the majority goes to mental health: 86% of total State and local spending for mental health and substance abuse went for mental health in 1997.

- Respondents from States where services are provided by some entities that combine substance abuse and mental health services and others that provide specialty substance abuse treatment services only reported that combined or integrated services had the following characteristics:
    - The definition of co-occurring disorders is broadened so that a much larger proportion of substance abuse patients are diagnosed with a mental health disorder.
    - Mental health practitioners and substance abuse practitioners have different evidence-based best practices and little or no cross training. Combining services administratively does not necessarily address this issue.
    - Practitioners with a mental health background are more likely to diagnose substance abuse patients as having mental health disorders than substance abuse disorders, an observation similar to what has been amply demonstrated in the literature on primary care physicians' propensity to diagnose some mental health disorders but to miss substance abuse disorders.

- Centralizing budget and fiscal functions that were formerly within the State substance abuse agency has been a component of consolidation efforts in several States. Staff from these departments believe strongly that this centralization caused in a loss of programmatic expertise, focus and priority in the substance abuse budgetary function. The centralization resulted in a lack of ability to understand or model the policy implications of proposed changes in substance abuse budgets and finances. Substance abuse financing/reporting required under the Federal Block Grant was believed by these individuals to have been negatively affected when the functions were centralized upward.

- Clients with co-occurring mental health and substance abuse disorders benefit both from mental health and substance abuse treatment services. According to the Federal Drug and Alcohol Services Information System, only 16% of substance abuse treatment admissions in 2001 were for clients with a

[6] SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1997* DHHS Publication No. SMA 003499 2000

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co-occurring mental health disorder[7], which was not necessarily a serious mental illness. Although this is probably a significant underestimate, since many of the programs that are funded by the SAPT block grant and supply the data for this observation do not have mental health professionals qualified to make a diagnosis of a mental health disorder, the point remains that most people who are treated for substance abuse are not found to have a mental health disorder.

Turning to the epidemiologic perspective, 23.2% of the members of the targeted public mental health population, clients with severe mental illness (SMI), also have a substance use disorder[8]. Moreover, about 29% report use of an illicit drug in the past year. Among adults with substance dependence or abuse, 20.4% had SMI, according to the National Survey on Drug Use and Health. The great majority of SA clients do not meet the public sector criteria for SMI necessary for entitlement to State-provided mental health services.

TABLE II

PERSONS AGED 18 OR OLDER WITH SERIOUS MENTAL ILLNESS (SMI) AND SUBSTANCE USE DISORDER (SUD)
2002[9]
(Thousands)

		SUBSTANCE DEPENDENCE/ABUSE		
		YES	NO	TOTAL
SMI	YES	4,048	13,435	17,483
	NO	15,749	159,674	175,423
	TOTAL	19,797	173,109	192,906

Because the intersection of the target populations for the two conditions in the general population – those who report serious mental illness and substance dependence/abuse – is such a small proportion of the total of the two populations (12.2%), treating co-occurring disorders may be more of a programmatic and clinical issue than an organizational placement issue within

[7] SAMHSA, Office of Applied Studies, *The DASIS Report*, "Admissions with Co-occurring Disorders: 1995 and 2001" April 9, 2004
[8] Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04–3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
[9] *ibid*

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state government. Basing a system reform or restructuring on treatment of co-occurring disorders affects only about one fifth of the SA population, while ignoring other concomitant problems of many persons with substance abuse disorders.

Regardless, it must be recognized that substance use and abuse is an important issue in the treatment of those with SMI. Not only do a significant portion of the clients in the public mental health population with SMI have a substance use disorder (SUD), but substance use by these clients, even in those without SUD, can significantly undermine behavioral stability. Moreover, the prevalence of SUD in the SMI population is higher in urban areas, higher for adolescents than for adults and may be higher among public sector clients than in the population treated elsewhere. Therefore, collaboration with the State substance abuse agency is of critical importance for State mental health agencies, whereas the State substance abuse agency perceives the mental health agency as one of many State agencies with which collaboration is needed. This disequilibrium in perspectives is a potential source of tension between the two agencies. Several substance abuse agency Directors indicated that they felt more need to collaborate with criminal justice agencies than with mental health agencies.

The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency that its ability to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control on behalf of its clients. However, the evidence developed to date in this nine State study clearly indicates that this submersion or merger would or actually has significantly degraded the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to collaborating with the mental health agency.

Other Significant Policy Issues Raised by Respondents

- Political attitudes towards and sympathy or lack of support for substance abuse treatment have an importance beyond structure and leadership:
    - One strong Director in a "nested" (See definition, following) department mentioned that over the past five years there had been four individuals in positions superior to his in the Department: two

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CADPAAC Response to Health and Human Services Agency Stakeholder Survey

California Performance Review Recommendations

The following comments constitute the response of the County Alcohol and Drug Program Administrators Association of California (CADPAAC) to the Stakeholder Survey. These comments address the specific recommendation of the California Performance Review that the administration of the state's substance abuse and mental health programs be consolidated.

Recommendations on Programs Administered by Government:

Question 1: Will the proposal improve access to services? Does it make it simpler for customers/clients?

Answer: CADPAAC believes that the proposal may improve access to services for those clients diagnosed with co-occurring mental health and substance abuse disorders. However, recent figures from the federal Substance Abuse and Mental Health Services Administration indicate that only 23% of adults with serious mental illness have a co-occurring substance use disorder, and only 12% of the combined population of individuals with either substance use disorders or serious mental illness have both diagnoses. While service access to this population may be improved, the consolidation proposal will substantially reduce or disrupt the availability of and access to services for the vast majority of clients with an alcohol or other drug abuse disorder. Currently, clients with alcohol and other drug (AOD) abuse issues are well served in counties with easily-identifiable and distinct programs providing AOD prevention and treatment. CAPDAAC fails to see how it would be "simpler" for these clients to navigate through a behavioral health or mental health system to find the appropriate services they need. The primary barrier to treatment access is not organizational, but the fact that both the AOD and Mental Health systems are severely under-funded relative to need.

Question 2: Will the proposal improve delivery of services?

Answer: CADPAAC believes that service delivery for most clients with AOD-specific needs will be severely curtailed under this proposal. Reimbursements, contracts, reporting issues, etc. are very different for AOD services than for mental health. Moreover, the fact that mental health services, most of which are mandated, are given funding priority over discretionary AOD programs, would mean that AOD services are more vulnerable to reduction or even elimination.

Question 3: Will the proposal improve outcomes?

Answer: As with service delivery, outcomes may improve for a minority of clients diagnosed with co-occurring disorders. However, for the majority of clients with AOD-specific needs, positive treatment outcomes may decline in a new department that focuses on behavioral health. In Santa Clara County, for example, actual data for the last complete year show that only 1-2% of clients in both the AOD and Mental Health systems combined are treated in both systems during the year. Just over 10% of the total number of clients in both systems were seen in both systems at some time during the year, but not concurrently. While various estimates show much higher figures, depending on the studies cited, when actual numbers from a major county are used, the overlap of clients between the two systems is very small.

Question 4: What will be the impact on the service provider network?

Answer: This question could be better answered by the providers themselves. CADPAAC believes the AOD service provider network will be negatively impacted by this proposal. Providers that contract with county AOD administration or with the State Department of Alcohol and Drug Programs (ADP) are subject to federal requirements, contracts and cost reporting systems, Drug/Medi-Cal contract monitoring, data collection and reporting, licensing and certification, oversight and evaluation activities for various criminal justice programs, all of which are much different for AOD programs than for mental health. Providers could face substantial disruption of and costly changes in their programs under the Commission's proposal.

Question 5: Will the proposal improve program efficiency?

Answer: CADPAAC believes that the proposal will ***reduce*** program efficiency. AOD programs that receive Federal funding are subject to specific Federal accountability standards and maintenance of effort (MOE) requirements distinct from mental health programs. Without a separate state department to administer these services, efficiency will be compromised.

Recommendations on the Organization/Structure of Government:

Question 1: Will the reorganization proposal improve service delivery and outcomes for clients?

Answer: As with Question #1 above, CADPAAC believes that for clients diagnosed with co-occurring AOD addiction and severe mental illness, the proposal may improve service delivery and outcomes. However, the proposal will ***reduce*** service delivery and outcomes for most AOD clients, for the reasons enumerated above.

Question 2: Will the proposal promote better coordination and integration of policy and programs for specific client groups?

Answer: As the Little Hoover Commission concluded, coordination of programs is best promoted on the local level by leadership development, replication of successful collaborations, and removal of barriers to cooperation, rather than by department merger at the State level. CADPAAC believes that the merger proposal would actually hinder the coordination of AOD services with other systems impacted by AOD issues, such as criminal justice, public health, child welfare and social services.

Question 3: Does the proposal provide better accountability for specific client groups?

Answer: CADPAAC believes that the proposal will not provide as good accountability for AOD clients as currently provided by a separate State department for alcohol and drug programs.

Question 4: What are the strongest reasons for implementing this recommendation? What are the greatest potential concerns?

Answer: The strongest argument in support of this proposal is that some counties have already consolidated AOD and mental health services within a behavioral health model. While such consolidations may have achieved a measure of administrative streamlining and cost savings at the local level, there is still great debate as to whether clients with AOD-specific needs are being well served by a behavioral health system. Moreover, there are no valid studies or data as to any real cost savings that would accrue as a result of the merger of the two departments at the state level.

CADPAAC's greatest concerns about the proposed consolidation are outlined in its letter of public comment to the California Performance Review Commission (attached).

The Stakeholder Survey also invites comments and suggestions as to how given recommendations could be modified to better advance their intended objectives. If the goal is to improve the efficiency of AOD programs, CADPAAC would recommend implementing the Little Hoover Commission's proposals as outlined in its 2003 report, ***For Our Health & Safety: Joining Forces to Defeat Addiction***. The LHC's five recommendations are:

1. The establishment of a State Council to develop a unified strategy to cost-effectively reduce the expense, injury and misery of AOD abuse.
2. Working with counties, the State should set broad goals for treatment programs, and help counties to ensure that treatment is available to those whose substance abuse imposes the greatest harm on their communities.

3. Implementation by the State of outcome-based quality control standards for treatment personnel, programs, and facilities, and encouragement of continuous quality improvement.
4. Facilitation by the State of the integration of AOD treatment with other social services to effectively reduce abuse and related public costs.
5. The State should immediately maximize available resources that can be applied to AOD treatment.

It is interesting to note that, in its recommendation to integrate AOD treatment with other social services, the Little Hoover Commission nowhere suggests that this goal would be achieved or furthered by the statewide consolidation of AOD and mental health services. Rather, integration is best achieved by the development of leadership in all fields, the replication of successful cooperative programs on the local level, and the creation of a process to identify and remove barriers to collaboration. CADPAAC would agree with these goals, and believes that the proposed AOD-Mental Health consolidation would jeopardize the collaboration of AOD services not only with mental health, but with criminal justice, public health, education, child welfare, social services, and other systems that are impacted by alcohol and drug abuse issues.

Analysis of CPR Recommendation to Consolidate Mental Health and Alcohol and Drug Programs

Importance of State Substance Abuse Services and Policy

- Untreated substance abuse imposes significant costs on many parts of the community and state government:
  - Excess physical health costs and overuse of costly emergency services
  - Endangers public safety, causes auto and workplace accidents
  - Endangers child welfare; increases domestic violence
  - Overcrowds state criminal justice facilities and courts
  - Creates public housing problems and encourages and complicates homelessness
  - Degrades educational productivity and requires vocational rehabilitation
  - Degrades workforce productivity and safety
  - Complicates mental health and medical treatment
  - Increases burden on overburdened state and local police, courts, correctional systems, social services

Importance of Freedom to Collaborate

- Many other State agencies have significant numbers of difficult clients with substance abuse problems.
- State substance abuse agencies must collaborate with other agencies to implement effective SA policy and services.
- Effective collaboration requires the SA agency to be visible, autonomous and to have "clout".

CPR Uses Prevalence of Co-Occurring Disorders to Justify Consolidation

- CPR report states that "of those persons diagnosed with serious mental illness, 41% have alcohol or other drug disorders".
- On the contrary, more recently released figures from SAMHSA show that in 2002 only 23% of the adults with serious mental illness (SMI) have any substance use disorder (SUD) at all.
- Only 12% of the combined adult population of individuals with either substance use disorders (SUD) or serious mental illness (SMI) were found to have both diagnoses (SUD and SMI).

Co-Occurring Disorders Are a Clinical Issue

- CPR Report says that the prevalence of co-occurring disorders requires consolidation.
- Effective treatment of co-occurring disorders is an important programmatic and clinical issue but only for specific patients; the prevalence of 12% co-occurring disorders in the combined target populations of ADP and DMH is insufficient to serve as a rationale for consolidation, as opposed to cooperation, of the two departments.
- SUD's and SMI also "co-occur" very frequently with physical illnesses, developmental delays, criminal justice issues and social/economic problems. If co-occurrence were to be the logical basis for departmental mergers, one would need to examine whether ADP or DMH should be merged with these other functions or departments.

Specialized Nature of Alcohol and Drug Treatment

- CPR Report states that there are "increasing similarities in the [drug/alcohol and mental health] treatment approaches ... not fully understood or appreciated by the two disciplines".
- As evidence for this convergence, CPR Report cites the "recovery approach" and certification of treatment providers and staff.
- The similarities are said to justify consolidation.

Recovery and Certification Do Not Imply Need for Consolidation

- Recovery is a clinical, programmatic and spiritual/philosophical goal for all chronic disease, not a sound fiscal or policy rationale for merging any particular state departments that serve individuals with chronic disorders.
- Treatment providers and staff in substance abuse treatment require certifications quite different from those in mental health treatment. Certification is a mechanism used in many fields to require minimum standards for treatment providers and staff, not to justify merger when standards are so different.

Relapse and Substance Abuse

- To justify consolidation, CPR also attributes SUD relapse primarily to "untreated psychiatric disorders", citing a 1997 SAMHSA report.
  - A more recent (1998) meta-analysis of 69 such studies concluded that the phenomenon of SUD relapse was "complex" and that "no single variable strongly predicts continued drug use."
- CPR also quotes SAMHSA as saying "the most common cause of psychiatric relapse today is use of alcohol, marijuana, and cocaine." This 1997 statement by SAMHSA actually refers only to seriously mentally ill individuals **with co-occurring disorders**, not to all individuals with mental disorders as CPR states.
- Implication: CPR Report overstates relationship between mental illness relapse and substance abuse; relapse is a complex clinical phenomenon that has many reasons other than co-occurrence; it does not imply a need for consolidation of the two disciplines at the organizational level.

CDP Report Cites Mental Health Sources that Favor Consolidation

- National Association of State Mental Health Program Directors (NASMHPD) cited, but not the National Association of State Alcohol/Drug Abuse Directors (NASADAD) or CAADPE (California Association of Alcohol and Drug Program Executives).
- Administrator of newly combined Department in Oregon cited by CPR as in favor of consolidation was originally from mental health department.

CPR Neglected Substance Abuse Sources and Experience of Comparable States

- CPR did no analysis of the larger, more diverse, states that are comparable in population to CA (e.g. Texas, New York, Florida or Ohio), where MH and SA have not been merged despite recent reorganizations ordered by the legislatures and/or the Governors.
- California County interviewees cited in report were 7 directors (out of 57 counties) all of whom had combined responsibilities, not county SA directors and not the majority of CA counties.
- No evidence cited even in these instances that SA staff agreed with the 7 mergers or that these counties' stakeholders were pleased with their effects on clients.

CPR Neglect of Substance Abuse Sources

- No citations at all from national academic policy experts in SA (Thomas McClellan, PhD, Constance Weisner, Ph.D. – both on IOM *Crossing the Quality Chasm* Committee) – did not even cite UCLA researchers, UCSF researchers or UCSD researchers known internationally in SA clinical and policy research.
- No states cited where ADP/MH mergers were rejected or avoided (eg. Florida, NY, Texas, Ohio, Michigan).

Substance Abuse Agencies Across the US Oppose Merger with Mental Health

- Substance abuse agencies are much smaller than mental health agencies but have much higher proportion of Federal block grant funding.
- Consolidation subsumes the smaller department within the larger one, threatening MOE requirements and reporting attached to SAPT block grant.
- In general, mental health departments prefer consolidation with substance abuse departments and substance abuse departments oppose consolidation.
- State substance abuse agencies typically believe that consolidation with mental health significantly degrades their ability to promote effective substance abuse services and policy. Those who have actual experience with consolidation have evidence of this problem.

Substance Abuse Agency Placement in Comparable Large States

- Texas
  - SA agency is co-equal to MH agency within the Community Mental Health and Substance Abuse Services Section.
- New York
  - SA agency at cabinet level with Director appointed by Governor
  - Last major re-organization in 1995-1996 replaced a "super-agency" with three separate units: SA, MH and MRDD.
- Florida
  - Director of SA agency is also Deputy Director for Treatment in Florida Office of Drug Control; has direct access to Governor.
  - Director of SA and Director of MH report that SA agency used to report to mental health agency; now that it is co-equal to MH, SA has been able to promote SA priorities in a way that he was never able to when subsumed under MH.
- Ohio
  - SA agency at cabinet level with Director appointed by Governor.

ADP and DMH Have Different Organizational Funding and Focus That Makes Consolidation Problematic

- Targeted DMH focuses on persons with SMI and has relatively low Federal block grant funding; ADP focuses on serving everyone with dependence or abuse problems, whether or not severe – all of whom are also clients of almost every other state department and ADP has high proportion of funding from Federal block grant; consolidation would endanger ADP compliance with Federal block grant requirements.
- DMH culture and organizational emphases not in synch with these differences. Consolidation of ADP with DMH is not likely to empower ADP to collaborate with other state departments as is necessary. Collaboration that saves CA money will be obstructed (eg Prop 36).

CPR Analysis: Purpose, Method and Requirements

- Charge from Governor: Based on evidence of performance deficits, Identify opportunities for savings, efficiencies and performance improvement across state government
- Method: Use evidence-based and balanced policy analysis and assessment to yield valid recommendations for major policy changes and organizational designs
- Requirements for such policy analysis: absolute accuracy and thoroughness in developing evidence; citing up-to-date evidence regardless of what that evidence shows; non-selective use and reporting of complete and unbiased analysis of that information; savings or cost estimates based on valid data that support savings projections; complete understanding of agencies' missions, funding and stakeholders' needs and requirements; analysis subjected to fair and thorough external review by recognized SA and MH subject matter experts; implications and recommendations supported by evidence, not author preference.

Policy Analysis Requirements vs. CPR Analysis of ADP/DMH Issues

- Accurate, thorough use of evidence? No
- Use of latest scientific evidence? No
- Non-selective, complete data? No
- Unbiased sources and data analysis? No
- Complete understanding of agencies' missions, funding and stakeholder needs and requirements? No
- Review of analysis and recommendations by qualified expert subject matter experts from SA and MH? No
- Recommendations supported by data? No

ACHSA Issues/Concerns Re: Potential Merger of ADPA with LACDMH

1) Potential difficulty with the integration of conflicting cultures.
   [According to the 2004-2005 L.A. County Civil Grand Jury Report, "There has been much controversy within the mental health and substance abuse communities regarding the relationships between the two populations of clients. During interviews we were advised that substance abuse clients generally do not want to be 'stigmatized' by being associated with mental illness. On the other hand, mental health clients and their families see mental illness as a disease which encompasses much more than the substance abuse issues that are presented by the patients."]
2) Ability of DMH to absorb new program within the existing organizational structure at the macro level (Finance, Contracts, Management by District Chiefs).
3) Increased burden on DMH administration at the micro level (with 300 new ADPA contracts to process).
4) Would the merger (actually technically referred to as "nesting") result in a true "integration" between ADPA and DMH? While the two programs could be housed in the same department, would they have equal standing and be able to achieve integration?
5) How would mental health providers feel about the establishment of a new Behavioral Health Department, with co-equal Mental Health and Substance Abuse Divisions?
   [According to CAADPE, if the Board of Supervisors ultimately approves the merger of ADPA into LACDMH, the drug and alcohol providers would fight hard for such an integrated new department, which is probably the only way they would live with the merger.]
6) Same concern of drug and alcohol clients and providers as mental health clients and providers have had when the prospect of DMH being subsumed by DHS was being proposed -- an inadequate voice and consideration among other priorities.
7) Concern that if ADPA is merged with DMH the drug and alcohol CBOs would receive less contracted funds (fear that the merger would lead to money being redirected to directly operated programs).
8) How would DMH administer traditional ADPA programs (e.g., drunk driver programs; Penal Code 1000 deferred entry of sentencing; funding of community coalitions that deal with alcohol/drug related issues such as billboards)?
9) With regard to ACHSA, there would be a larger group of potential member agencies. However, due to the small size of the majority of contracted ADPA providers, there would be a question as to affordability of ACHSA membership. Some existing ACHSA member agencies may also consider potential new ADPA member agencies as "diluting" the Association.
10) Since ADPA is the largest pot of money with the County Department of Public Health, the future of that department would be put in question (countywide issue).
11) Given the current financial situation at the county, state, and federal levels, it is questionable as to whether this would be the best time to implement this proposed merger or create a new behavioral healthcare department.

Key Findings from SAMHSA Study, Dated 8/17/04, on Analysis of Placement of Alcohol and Drug Abuse Services within Different State Administrative Structures

1) To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within an agency that does not fully share its priorities and mission.
2) Collaboration with State mental health agencies is a key function for State substance abuse agencies. However, treating co-occurring disorders is more of a programmatic and clinical issue than an organizational placement issue within state government.
3) The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency or State government that the ability of the mental health agency to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control. However, the evidence developed to date in this nine State study clearly indicates that this submersion would significantly degrade the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to its collaboration with the mental health agency.

Conclusion and Possible Recommendations

1) By simply merging, or more accurately nesting, ADPA into LACDMH there is a lack of clarity as to any real benefit that would accrue to the clients served by either entity. While it might save the County money, by eliminating potentially duplicative administration, this benefit would be more than offset by the significant added administrative burden placed on LACDMH, which is already dramatically overburdened, likely causing negative impacts on current community mental health agencies and their clients.
2) The potential benefits of increased integration could be obtained by the development of improved working relationships between ADPA and LACDMH outside of the merger.
3) It is recommended that ACHSA not take a formal position on this proposal, but rather meet with Phillip Chen, Supervisor Antonovich's Health Deputy, to share some of our issues and concerns. Key agencies within the Supervisors' district would be attempting to help educate Phillip rather than attack what is undoubtedly a well intended idea.
4) It is recommended that ACHSA also consider meetings with Dr. Southard and Deputy CEO Sheila Shima on this proposal.

Los Angeles County
Department of Regional Planning

Planning for the Challenges Ahead

Jon Sanabria
Acting Director of Planning

April 8, 2009

TO: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

FROM: Jon Sanabria
Acting Director of Planning

SUBJECT: Response to Board Motion Regarding Mitigation Monitoring Program (October 7, 2008, Item #94-F)

The following is the Department of Regional Planning's (DRP) response to Supervisor Zev Yaroslavsky's motion of October 7, 2008, directing that we report back to the Board regarding 1) the adequacy of DRP's existing mitigation monitoring program compliance checks 2) the amount of available funding the Department has dedicated to this effort, the amount the Department has been collecting and expending over the past two years, and the amount it expects to collect in the future, 3) staffing plan and 4) recommend mechanisms for ensuring the fees are consistently collected and inspections are performed as required in mitigation monitoring.

Adequacy of Existing Mitigation Monitoring Program

The Impact Analysis Section of the Department of Regional Planning is confronted with increased workload requirements pursuant to Section 21081.6 of the State Public Resources Code. A number of significant projects have been approved with Mitigation Monitoring Programs since this law became a requirement in 1991. As these projects enter the development phase, the Department of Regional Planning is required to actively review, monitor and take appropriate action with respect to the adopted programs. Failure to administer these programs results in violation of State mandates.

In the past, mitigation monitoring has been divided among Impact Analysis staff in addition to other duties. This has proven ineffective in that staff has not been able to devote the necessary time to monitoring the mitigation measures. As a result, some approved projects have been found not in compliance with the Mitigation Monitoring Program requirements. This non-compliance with mitigation measures has caused an increase in the number of investigations conducted by the Department's Zoning Enforcement Section.

The Department does not currently have sufficient staff to successfully carry-out the goals of the program by continuously monitoring the Board of Supervisors and Regional Planning Commission's approved mitigation measures. The addition of dedicated staff would allow for implementation of the Mitigation Monitoring Program.

This would achieve the desired increase in project oversight. Revenue generated from continuous monitoring would fully offset this position for seven years. Implementing the aforementioned programs at this time may avoid future potential costs associated with possible legal action against the County.

Funding For Mitigation Monitoring Program

The balance for the EIR mitigation monitoring account was $386,235.00 as of April 2, 2009. The amount of money collected over the past two fiscal years included $63,537.64 during FY06-07 and $52,319.99 during FY07-08. The amount expended was $8,390.29 during FY06-07 and $6,887.79 during FY07-08. The Department anticipates collecting at least $40,000 to $45,000 per year in the future for mitigation monitoring. As long as the need for mitigation monitoring exists there will be adequate funding to offset the costs.

Staffing Plan, Fee Collection and Required Inspection

The Department is proposing the addition of one Regional Planning Assistant II position to ensure that the mitigation monitoring function is adequately and consistently performed. The technically sophisticated standards and criteria that are often associated with various mitigation monitoring measures sometimes may require additional review by a biologist. The RPA II can be supported by a contract biologist who is currently serving the Department on an as-needed basis.

The Impact Analysis Section in conjunction with the Budget and Accounting Services Section will monitor the employee's timesheets to ensure all work on mitigation monitoring is properly coded and billed. In addition, the Accounting Services Section will provide management with monthly mitigation monitoring account balances and send out supplemental deposit letters to applicants when needed. The Impact Analysis Section will ensure that its staff performs inspections as required in mitigation monitoring programs. All costs for this position will be revenue offset.

If you have any questions regarding this matter, please contact Paul McCarthy of the Impact Analysis Section at (213) 974-6461. Our offices are closed on Fridays.

JS:SA:lm

C: Chief Executive Office
Executive Officer, Board of Supervisors

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WILLIAM T FUJIOKA
Chief Executive Officer

August 19, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

PROGRESS REPORT – POTENTIAL TRANSFER OF ALCOHOL AND DRUG PROGRAM ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

On October 7, 2008, your Board approved a motion by Supervisor Michael D. Antonovich instructing the Chief Executive Office to develop recommendations to the Board within 30 days regarding the transfer of Alcohol and Drug Program Administration from the Department of Public Health (DPH) to the Department of Mental Health (DMH). On October 24, 2008, we advised that additional time would be necessary to complete a comprehensive analysis given the significance and potential impact of the proposed transfer. On July 1, 2009, we provided your Board an interim status report indicating that a workgroup of CEO and departmental staff was convened, background material applicable to this study was complied, programs currently integrated within the two departments were examined, and we sought and evaluated opinions about potential issues, and provided the pros and cons of such a transfer. We also reported that we would be meeting with the DPH and DMH advisory commissions to allow the stakeholders an opportunity to comment on the issue.

This memorandum is to inform you that we met with the DPH and DMH advisory commissions, and at their meeting, the Mental Health Commission requested additional time to review the July 1, 2009 interim status report, and discuss it at their August 13, 2009 Executive Committee meeting. We anticipate receiving their comments shortly. Following our review of commission comments, we will complete our final analysis and anticipate submitting our final report to your Board by September 4, 2009.

If you have any questions or need additional information, please contact me, or your staff may contact Richard Martinez at (213) 974-1758 or rmartinez@ceo.lacounty.gov or David Seidenfeld at (213) 974-1457 or dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
MLM:TOF:yb

c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Mental Health
Director and Health Officer, Department of Public Health
Mental Health Commission
Commission on Alcoholism
Narcotics and Dangerous Drugs Commission
Public Health Commission

081909_HMHS_MBS_Potential ADPA Transfer